Now part of ALLSCRIPTS

HealthMatics EMR

Application Reference Manual

May 9, 2006

Statement of Confidentiality

The information contained herein is proprietary and confidential to A4 HEALTH SYSTEMS®. No part of this document may be reproduced or transmitted in any form or by any means, electronic, written, or mechanical, including, but not limited to, photocopying and recording, or by any information storage and retrieval system, without prior written permission from A4 HEALTH SYSTEMS.

Statement of Accuracy

This document is thought to be fully consistent with the level of product it describes at the time of printing. Information is subject to change without further notification. A4 HEALTH SYSTEMS does not assume any liability, or provide any guarantees for the contents of this publication.

If you have any comments concerning this document, contact the Education Specialist at A4 HEALTH SYSTEMS.

Statement of Responsibility

Client agrees to be fully responsible for the operation of the system as outlined in the HEALTHMATICS User Manual and in accordance with the laws of its state.

To contact A4 HEALTH SYSTEMS:

A4 HEALTH SYSTEMS
5501 Dillard Drive
Cary, NC 27511-9234
USA

Phone: (888) 672-3282
(919) 851-6177
Fax: (919) 851-5991

Web site – http://www.a4healthsystems.com

Revision History and Copyright/Trademark Information

Original Release Date: 5/11/06

Revision Release Date: 5/11/06

Copyright 2005, A4 HEALTH SYSTEMS®. All rights reserved. Printed in USA.

A4 HEALTH SYSTEMS® and HEALTHMATICS® are Registered in the US Patent and Trademark Office.

RSMrefresh, Copyright (C) 2005 A4 Health Systems

Table of Contents

1. Office Functions 1
Login 1
EMR Desktop 2
Using the title bar 2
Using the menu bar 3
Using the toolbar 4
Using the status bar 5
Monitoring workflow on the desktop 6
Windows, Panes, and Other Tools 8
Resizing panes and columns 8
Sorting columns 8
Understanding table font conventions 8
Using drop-down lists 8
Using scroll bars 9
Using secondary toolbar icons and shortcut keys 9
Right-clicking for pop-up menus 10
Entering dates 10
Entering phone numbers 10
Checking spelling 11
Configuring spell check 12
Using pen-based functions 13
To set dates 13
To access the keypad 14
To access the numeric keypad 14
Patient Search 14
Appointments 15
Scheduling appointments in HealthMatics EMR 17
Checking patients in and out 18
Searching for patient appointments 19
Changing or editing appointment information 20
Blocking time on schedules 20
Printing daily schedules 20
Displaying daily billing information 21
Open Encounters 22
Outstanding chart messages 22
Inbox 24
Filtering inbox items 24

Status bar inbox filters . . . 24
Inbox item icons . . . 26
Performing inbox tasks . . . 26
Deleting messages from the inbox . . . 27
To delete messages without opening them . . . 27
To delete inbox messages after opening them . . . 27
Viewing other caregivers' inboxes . . . 28
Result Notifications . . . 29
Viewing notification messages and results . . . 29
Determining who receives message notifications . . . 30
Blocking result notifications . . . 31
Messages . . . 32
Viewing the list of messages . . . 32
Entering data on tabs . . . 32
Sending mail messages . . . 37
Sending patient messages . . . 39
Responding to patient messages . . . 40
Viewing patient messages saved to charts . . . 42
Web Messages . . . 43
Refill Requests . . . 44
Sending refill requests . . . 44
Viewing refill requests . . . 46
Approving or rejecting refill requests . . . 48
Using prescription properties . . . 51
Displaying outstanding refill requests from patients . . . 54
eRefill Requests . . . 55
Viewing eRefill requests . . . 56
Manually matching eRefill requests . . . 57
To match patients . . . 58
To match pharmacies . . . 59
To match maintenance medications not previously recorded . . . 60
Approving matched eRefill requests . . . 60
Rejecting eRefill requests . . . 62
Rejecting eRefills and sending new prescriptions . . . 63
Sending new prescriptions electronically . . . 63
Setting up electronic prescribing in administration . . . 66
To assign prescribing agents for caregivers . . . 66
To set refill request password prompts . . . 66
To run ePrescribe synchronization immediately . . . 67
Setting up electronic prescription pharmacies . . . 67
Using biometric authentication with electronic prescriptions . . . 68

To add biometric authentication system options 68
To use biometric authentication with electronic prescriptions 69
Documents 70
Viewing the list of documents 70
Approving or rejecting documents 71
To approve or reject external transcriptions 71
To approve or reject internal (voice note) transcriptions 73
To approve or reject scanned documents 74
Viewing scanned documents from face sheets 76
Action Items 77
Creating action items 77
Viewing action Items 78
Responding to action items 79
Received Charts 80
Reports 82
Processing report messages 82
Performing mail merges 83
Internet from Inside HealthMatics EMR 84
Outlook Inbox 85
Creating Outlook emails in the EMR 85
Emailing H&P reports from face sheets 86
Outbox. 88
Batch Refill 89
Processing refill requests in batch refill 89
Viewing refill documentation on face sheets 90
Output Queue 92
Viewing documents from the output queue 92
Adding electronic signatures from output queue 94
Printing from the output queue 94
Faxing from the output queue 94
Saving to log 95
Exporting from output queue 96
Viewing output queue action history 96
Creating new output from the output queue 97
Quick Filters 98
Creating quick filters 98
Setting user defaults for quick filters 98
Using quick filters 99
Worklogs 100

Tracking chart contact using worklogs 100
Filter by caregiver 101
Filter by machine 102
Filter by patient 103
Using the worklog toolbar functions 103
Tracking patients during visits 104
Billing Reconciliation 105
Audit Open Encounters 107
Options 108
Changing passwords 108
Editing options 108
To set desktop defaults 109
To customize your toolbar 110
To set face sheet defaults 114
To set patient manager defaults 116
To set results defaults 117
To set reason for visit defaults 118
To set review of systems and physical exam defaults 119
To set vitals defaults 121
To set assessment and plan defaults 122
To set electronic prescription defaults 123
To set sign off defaults 124
To customize the title bar 125
To set history defaults 126
To customize quick lists 127
To sort or delete my short lists 128
Editing grants 129
Editing output defaults 130
Editing default locations 131
Editing auto replace text 131
Internal Transcription 135
Practice Management System Interface 138
2. Chart Functions 139
Patient Charts 139
Pulling charts 139
To pull patient charts for billing 139
To pull charts for concurrent encounters 140
To pull patient charts for non-billable contact 140
To review open encounters 141
To enter reason kept open 142
Sending charts to other caregivers 142
Reviewing received charts 143
Filing charts 143

To file an open chart from the toolbar . . . 143
To file charts from the desktop or status bar . . . 143
Printing entire charts . . . 144
Face Sheets . . . 145
Viewing and revising problems from face sheets . . . 147
To view problems . . . 147
To revise problem status . . . 148
To revise diagnoses from face sheets . . . 150
To print problems . . . 150
Viewing and revising history from face sheets . . . 151
To view history . . . 151
To view/edit immunization history from face sheets . . . 152
Viewing and revising encounters from face sheets . . . 153
To view encounters . . . 153
To view approved SOAP and general transcription (external transcription) . . . 154
To view voice notes (internal transcription) in the chart . . . 155
To view scanned documents in the chart . . . 155
To move attachments/messages to other encounters . . . 156
To change encounter information or create addenda . . . 156
Viewing and revising medications from face sheets . . . 157
To inactivate medications automatically . . . 158
Viewing orders from face sheets . . . 158
To view results from the orders pane . . . 159
To view results from the encounter pane on H&P reports . . . 160
Demographics . . . 162
Accessing patient demographics . . . 162
Entering/editing patient demographics . . . 163
Printing patient demographics . . . 166
Entering patient insurance information . . . 167
To enter insurance carriers into the EMR database . . . 169
Entering emergency contacts . . . 171
Loading patient pictures . . . 172
Patient Manager . . . 173
Lab Results . . . 175
Entering lab results . . . 175
Reviewing lab results . . . 178
To review lab results from review results . . . 178
To review lab results . . . 178
Finding lab results . . . 182
Annotating lab results during review . . . 183
Publishing lab result comments with read receipts . . . 184
Emailing/printing lab reports for one patient . . . 186
Emailing/printing lab reports for all patients . . . 186

Rules controlling date selections in lab results 187
Routing lab result notifications 187
Procedure Results 188
Defining procedures as billable or non-billable 188
Entering procedure results 189
Reviewing procedure results 191
Viewing final, not reviewed procedure results 193
Viewing final, reviewed procedure results 193
Setting performance dates for historical procedures 194
Additional Results 195
Processing referrals 195
To access referral results 195
To review final referral results 197
Processing authored text 197
Report Results 198
Result Summaries 199
Viewing result summaries 199
To view spreadsheets - default view 202
To view graphs 203
Creating new result summary graphs 203
Flow Sheets 206
To add flow sheets 206
To correct erroneous entries on flow sheets 207
Chart Attachments 208
Adding chart attachments 208
Linking chart attachments to office visits 209
Viewing chart attachments from face sheet 210
Reminders 211
Creating reminders on patient charts 211
Viewing and completing reminders 212
Lab Order Entry 214
Accessing lab order entry 214
Viewing lab orders 215
Creating requisitions 215
To create requisitions 215
To enter specimen collection information 218
Answering ask on entry (AOE) questions for orders 222
Viewing/editing ask on entry questions on requisitions 224
Deleting requisitions 226
Printing requisitions 226

Processing requisitions 227
To access requisitions 227
To resend requisitions 228
To print labels 228
Processing requisition batches 228
To access batch processing 229
To create lab order batches 229
To edit lab order batches 231
To delete lab order batches 231
To preview and print batch manifests (packing lists) 231
Patient Merge 232
Manually merging patient charts 232
Using the merge queue 235
Reviewing merge history 236
3. Patient Contact Functions 237
Data Libraries 238
My Short Lists 239
Specifying my short lists for assessment/plan 239
Specifying my short lists for reason for visit 239
Specifying my short lists in history 240
Setting caregiver options for my short lists 240
Adding my short list items to current encounters 242
Vitals 242
Documenting vitals 242
Documenting/printing growth charts 245
Viewing vitals in physical exam 246
History 247
Viewing history during an encounter 247
Documenting/adding history from previously entered history 248
Editing current encounter history items 249
Removing history items from current encounters 250
Indicating no history is available or exists 251
Including past medical history in current encounters 251
Indicating history is non-contributory to current problem 252
Documenting history using short lists 252
Documenting history using search 254
Documenting history using free text 254
Managing problem and medication history 255
To manage medications from history 256
To view managed history items on the assessment/plan screen 257

Reason for Visit 258
Documenting reason for visit 258
To document reason for visit using previous complaints 258
To document reason for visit using my short lists or short lists 259
To document reason for visit using the master list 260
To document reason for visit using free text 261
To document reason for visit using patient words 262
Documenting complaint characteristics and details 262
ROS and PE Navigation. 266
Using the navigation pane in ROS and PE 266
To navigate using the review of systems (or physical exam) tab 266
To navigate using the map tab 267
To navigate using the selected tab 268
To navigate using the my ROS (PE) lists tab 268
To navigate using the search tab 271
Using the preview pane in ROS and PE 271
Using the documentation pane in ROS and PE 272
To document using quick search 274
To navigate using key strokes 275
To document measurements and sizes 276
Using the toolbars in ROS and PE 277
Review of Systems 278
Documenting ROS using templates 278
Documenting ROS using previous encounters 280
Documenting review of systems from the beginning 281
Adding review of systems notes 282
To add ROS notes at the review of systems level 282
To add ROS notes at the system level 283
To add ROS notes at the detail level 283
Physical Exams 284
Documenting physical exams using templates 284
Documenting physical exams using previous encounters 285
Documenting physical exams from the beginning 285
To add physical exam notes 286
To add an image note 286
Documenting measurements and sizes in PE 288
Documenting physical exam using mapped images 289
Assessment/Plan 291
Viewing problem or medication history from A/P 291
To view problem history from A/P 291
To view medication history from A/P 292
To inactivate problems/medications from assessment/plan 292
Specifying assessments and plans 292

To specify assessments and medications using previous lists . . . 293
To specify assessments and plans using short lists . . . 294
To search for assessments and plans using database libraries . . . 294
To enter free-text diagnoses . . . 296
To indicate primary, secondary, and tertiary diagnoses . . . 297
To link multiple diagnoses to a procedure code . . . 298
To edit diagnoses in A/P . . . 299
To classify diagnoses . . . 299
Creating lab requisitions from assessment/plan . . . 300
Ordering on behalf of another caregiver . . . 302
To set order on behalf of caregiver option for A/P . . . 302
Ordering and viewing medications from assessment/plan . . . 303
To order new medications . . . 303
To view medication interactions . . . 306
To print, fax, or electronically transmit prescriptions . . . 306
To print medication patient education information . . . 307
To use formularies . . . 308
Using protocols . . . 308
Using procedure entry rules . . . 309
To order procedures with rules attached . . . 309
To enter results of procedures with rules attached . . . 310
Documenting referrals . . . 311
Option 1 - Select referral letters . . . 311
Option 2 - Make referrals using letters associated with caregivers . . . 315
Option 3 - Select referral letter from patient chart . . . 319
Using authored text in assessment/plan . . . 320
Setting patient authored text templates to *completed* in A/P . . . 320
Displaying quick assessment/plans . . . 321
Pregnancy Record . . . 322
Accessing the pregnancy record . . . 322
Documenting with the pregnancy record . . . 325
Editing pregnancy record screens . . . 326
To edit pregnancy record vitals - U/A . . . 327
To access pregnancy record pregnancy labs . . . 329
To edit pregnancy record review of systems . . . 329
To edit pregnancy record maternal/fetal data . . . 330
To edit pregnancy record cervix . . . 331
To edit pregnancy record medical Hx . . . 332
To edit pregnancy record OB history . . . 333
To edit pregnancy record pelvimetry . . . 334
To edit pregnancy record next appointment . . . 335
Including unsolicited test results in pregnancy records . . . 336
Printing the pregnancy record . . . 336
Immunization Records . . . 338
Accessing/viewing Immunization Record . . . 338

Editing immunization history . . . 339
To edit existing immunization history . . . 339
To add historical immunizations . . . 340
Printing immunization record . . . 341
Ordering and documenting immunizations . . . 342
Documenting immunization status . . . 342
To enter other free text immunization history . . . 342
To document immunizations using previously entered free text . . . 343
Notes . . . 344
Using text in notes . . . 344
Using images in notes . . . 345
To add images to notes . . . 346
Entering voice messages in notes . . . 349
Importing files as chart attachments . . . 351
H&P Report . . . 353
Viewing billing information . . . 354
Indicating reason charts are kept open . . . 355
Editing current H&P reports . . . 355
To edit current H&P reports . . . 355
To change or review notes in current H&P reports . . . 356
To view attachments from H&P report . . . 356
Finalizing encounters from H&P . . . 356
To conduct chart reviews . . . 357
To conduct performance reviews . . . 360
To print patient information documents without signing off on chart . . . 361
To send encounter billing information without signing off . . . 363
Signing off charts . . . 364
Evaluation & Management Calculator . . . 366
Accessing E&M calculator . . . 367
Understanding the E&M calculator . . . 369
E&M level . . . 369
Management options . . . 370
Data/risk . . . 370
Summarizing the service level . . . 370
Adjusting the service level . . . 373
Fast Track Templates . . . 374
Cancel Contact . . . 375
4. Printing and Faxing . . . 377
Print Terms . . . 377
Templates . . . 378
Printing from any view . . . 379

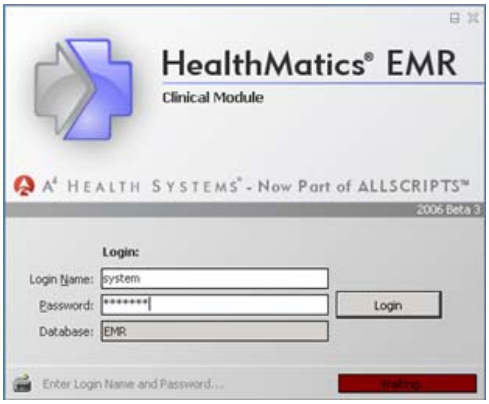
Faxing from any view 381
Queuing and saving to log from any view 382
Exporting from any view 382
Previewing documents from any view 383
Output Defaults 384
Creating output default sets 384
Using output default sets 385
Output Settings 385
Selecting output settings for each screen 386
Encounter packs 388
Creating encounter packs 388
Using encounter packs 389
Assigning access for refaxing or reprinting prescriptions 391
Quick Printing Reference 392
Printing from open encounters 392
Printing entire chart 392
Printing from appointments 392
Printing documents without signing off chart 392
Printing forms/letters and prescriptions from A/P 392
Printing no documents at sign off 392
Regenerating documents from output queue 392
Generating queued documents 393
Document Stages 393
Index 395

1. Office Functions

Before using HealthMatics EMR, become familiar with the functions available on the HealthMatics EMR desktop and how they can be used to monitor the workflow in your practice and to access the Internet.

Login

The Login screen displays the name of the application and the version level.

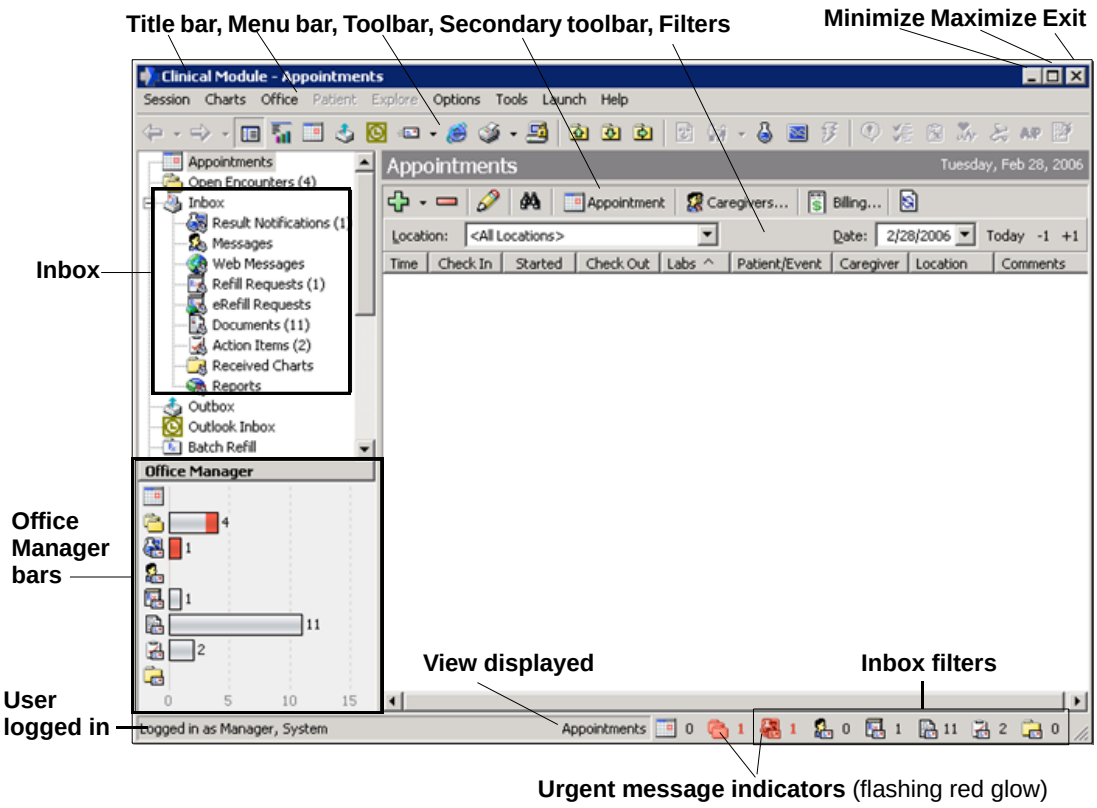


You can log in to HealthMatics EMR in either of two ways:

- **Login name and password**
  - > **Login name** - Login names must be at least five characters. A mixture of alpha and numeric characters provides maximum security. Privileges are attached to login names.
  - > **Password** - All users must have passwords. They must be changed periodically, as determined by the policy of your practice. Passwords are required for some application functions, including prescription signatures and chart sign offs.
- **Biometric authentication** - At the login screen, leave the password field blank and click **OK**.
  - > **IF** the password is blank, the biometric authentication hardware and software are installed, and your system administrator has enabled the Biometric Authentication system options, you receive a prompt for a fingerprint.
  - > **IF** any of the above conditions are not met, a message instructs: “Enter a valid password.”

EMR Desktop

1. Log in to HealthMatics EMR **Clinical Module**.
2. On the toolbar, click (View Desktop).
3. On the title bar, click (Maximize) if needed.



The HealthMatics EMR window has four bars to facilitate navigation and provide patient chart or work information.

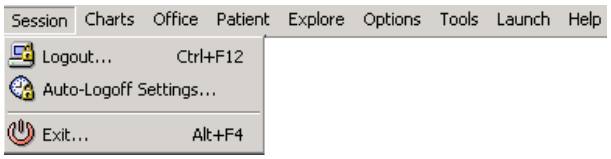
Using the title bar

The title bar is located at the top of all views. You can customize the title bar to display the information most important to your practice.

For a list of items and customization instructions, see To customize the title bar on page 125.

Using the menu bar

The menu bar is located directly beneath the title bar. Clicking a word on the menu bar displays drop-down menus with task commands.



Commands are enabled/disabled based on security privileges and whether a patient chart is pulled. When a command is not available, it is disabled and displays in gray font. (**Example:** If you have not pulled a patient chart, the **Patient** and **Explore** menu options are disabled (gray) on the menu bar, and are unavailable. Also, if you do not have privileges for a particular function, that menu option is not available to you.)

Session - From *Session*, you can control automatic logoff settings. If you have the appropriate read/write function access in HealthMatics Administration, you can set HealthMatics EMR to log off automatically after a set period of time with no activity:

1. From the menu bar, select **Session > Auto-Logoff Settings**.
2. Select **Enable Auto-Logoff**.
3. At *Logoff after*, enter the number of inactive minutes that must pass before the system logs off automatically and click **OK**.

Launch - From *Launch*, you can access either the Internet or other HealthMatics EMR modules, as well as any desk references that you have loaded onto your computer. From the menu bar, select **Launch >** (module you wish to access).

NOTE: If you do not have privileges to access a module, the system displays the following message: “This account does not have the proper privileges to access this application.” Clicking **OK** in the message box displays a login window that lets you enter a user name and password with the proper privileges.

- **Access administration** - If your practice has purchased HealthMatics Access, click to set up the module.
- **Administration module** - Click to set up or change HealthMatics EMR practice settings, caregivers, system options and interface queues.
- **Clinical customization module** - Click to customize knowledge, short lists, templates, catalogs, or to set up Lab Order Entry.
- **ePrescribe administration module** - If you have purchased ePrescribe functionality, click to modify settings for your electronic prescription transmission.
- **Input manager** - Click to input scanned documents and transcription, and to set up document types and scanning qualities.
- **Output manager** - Click to create templates using styles, layouts, and building blocks of patient information for all output documents that can be printed, faxed, or emailed.
- **Reporting module** - Click to build reports that generate patient reminders that display in *Patient Manager*.
- **Edit desk references** - Click to add or edit electronic reference sites that you want to be able to launch from within HealthMatics EMR.

To close a module and return to HealthMatics EMR, on the menu bar, select **Session > Exit**.

Help

- **References** - Click to access reference manuals for your HealthMatics modules in PDF form.
- **About** - Click to see the current HealthMatics EMR *Version* and *Build*, and to see *License Info*, *Clinical Products* version information, and *System Info* (including space available).

Using the toolbar

Toolbar icons are located directly below the menu bar. Icons are shortcuts for commands. You can select icons (shortcuts) for the commands you use most frequently and place them on the toolbar in your preferred order. Some commands are available only when a patient chart is pulled (if you have appropriate privileges). When commands are not available to you, the icons appear grayed out.

Example: In the standard toolbar shown below, icons are grouped into four categories. Vertical bars (separators) separate each category.

Workflow and communication | Chart handling | Chart management | Patient contact: documenting visits

- **Workflow and communication** - Commands to manage workflow and send messages to caregivers
- **Chart handling** - Commands to pull, file, and send charts
- **Chart management** - Commands to view and manage items in charts not connected to current patient visits
- **Patient contact during visits** - Commands for contact screens used to document current patient visits

For a list of all available icons and instructions for placing them on your toolbar, see To customize your toolbar on page 110.

NOTE: In addition to the main application toolbar, most views also have secondary toolbars that display immediately below the primary toolbar and contain additional icon shortcuts.

Using the status bar

The status bar is located at the bottom of the HealthMatics EMR window.

NOTE: The status bar may include other icons if you have purchased and turned on additional functionality, such as Web Messages from HealthMatics Access.

This bar displays no matter which view you are in. The user login in appears at the left, followed by the name of the view currently displayed (*Appointments*, in the example above). Shortcut icons for appointments (2) and open encounters (3) are followed by inbox filter icons.

Icon	Name	Action
2	Appointments	Accesses the schedule of appointments for the day # = patients checked in, but not out
3	Open Encounters	Lists encounters open on the desktop # = encounters in progress (not yet signed off)
1	Result Notifications	Lists lab and procedure results awaiting review # = Notifications never opened Flashing red = Notifications containing abnormal results. Flashing is optional (see Urgent message indicator on page 6). **NOTE:** The # increases each time a caregiver records a lab or procedure result marked *Preliminary, Final*, or *Canceled,* and decreases when you mark results *Reviewed*.
1	Messages	Lists messages in your inbox # = Total patient/mail messages **never opened**
1	Refill Requests	Lists refill/eRefill requests awaiting approval # = Total refill and eRefill requests in inbox -- both read and unread
11	Documents	Lists transcription and scanned documents awaiting review (or revision, if you are the transcriptionist) # = Total documents awaiting action
2	Action Items	Lists action items # = Incomplete action items **NOTE:** Action items (even if marked *Done*) remain in your inbox until deleted. Action items marked *Done* display in gray with a line through them.
0	Received Charts	Lists charts sent to you for review # = Number of charts awaiting review **NOTE:** Charts received could be for patients waiting in exam rooms, charts sent by other caregivers for review and sign off, or charts sent to you by other caregivers.

Urgent message indicator

A flashing red glow over the icon indicates the item was sent to you with urgency. All status bar icons, except *Open Encounters* and *Patients*, can flash for urgent messages. “Urgent” is defined below for each icon:

Icon for	Urgent Description
Results	Number of labs or procedures awaiting review containing abnormal results
Messages	Number of messages received marked high priority
Refill requests	Number of refill requests received marked high priority. (Note eRefill requests cannot be marked high priority.)
Documents	Number of documents received for review marked high priority
Action Items	Number of action items received marked high priority
Received Charts	Number of charts received marked high priority

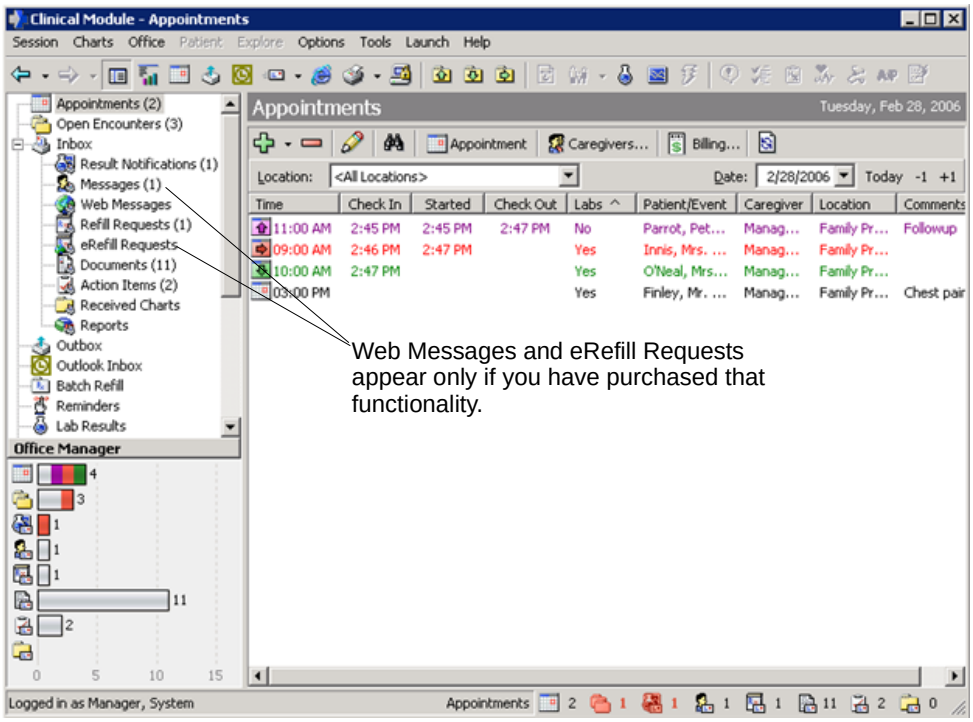
To turn the urgent message indicator on/off, follow the steps below:

1. From the HealthMatics EMR toolbar, select **Options > Edit Options**.
2. In the left pane select **Desktop** and, in the *Status Bar* box, select **Yes** or **No** for *Do you want the status bar icons to blink when you receive a High Priority item?*
3. Click **OK**.

Monitoring workflow on the desktop

From the HealthMatics EMR desktop, you can see in one view how your work is flowing. From both the *Office Manager* and the status bar, numbers, lists, stacks (bars), and urgency indicators all let you know where you are in terms of managing your appointments, messages, refill requests, documents (scanned and transcription), action items, charts, and reports. The HealthMatics EMR desktop displays a dynamic summary of your changing workload all in one window.

To access the HealthMatics EMR desktop, on the toolbar, click (Desktop).



- **Office manager** - From the desktop view, *Office Manager* shows a bar graph that indicates the number of items awaiting caregiver action in each category. The size of each bar and the number beside it change as work flows. Clicking a bar displays the list of items in that category to the right in the preview pane.
- **Lists** - The table that appears in the preview pane lists the items comprising each bar or view selected.
- **Pop-up menus for daily tasks** - You can right-click in the preview pane of all desktop views to display a menu of the most common associated tasks for each view.
- **Priority items** - In many views, items marked high priority, urgent, or labs with abnormal values display in red.
- **Appointment colors** - In the *Appointments* view, colors indicate whether the patients are scheduled (black), checked in (green), started (red), or checked out (purple).

Desktop information updates are based on your display preferences. (For details, see To set desktop defaults on page 109.) If you do not want to wait for the automatic update, manually update your desktop by clicking (Refresh) -- available on most secondary toolbars.

Windows, Panes, and Other Tools

Many views in HealthMatics EMR include tools to resize, search, and manipulate most views to ease your ability to locate and review the items they contain.

Resizing panes and columns

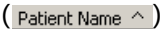
- **Panes**

Hover the cursor over the bar between panes until it changes to a double-bar, double-arrow shown in this example. Then click and drag it to resize the two panes. Bars may be vertical or horizontal.

- **Columns** - Hover the cursor over the bar between columns until it changes to a heavy line with a double-bar through it. Then click and drag it left or right to resize the two adjacent columns (

).

Sorting columns

Sort items in any column by clicking its heading. An arrow displays indicating that its items are sorted in ascending order (

) or descending order (

). Click the heading a second time to reverse the order.

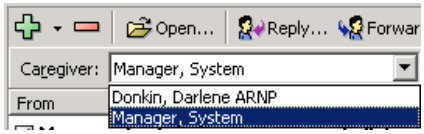
Understanding table font conventions

The table of items in views such as Result Notifications, Messages, Refill Requests, and others, follow these font conventions:

- **Red** - Items are marked *High Priority* or contain abnormal results.
- **Bold** - Items have never been opened.
- **Regular** - Items have been opened, but are still in the inbox.
- **Strike-through** - Completed items display grayed out with lines through them.

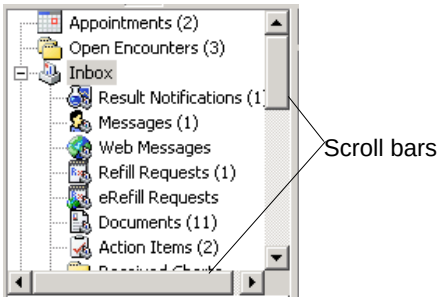
Using drop-down lists

Many screens have fields that provide the ability to select an item to limit or filter the information that displays. When filters are available, click the down-arrow to select an item from the list that displays.



Using scroll bars

If a scroll bar displays, either vertically or horizontally, view additional information by clicking and dragging the scroll bar to display the rest of the data.



Using secondary toolbar icons and shortcut keys

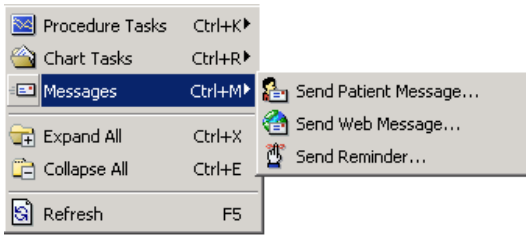
Most views have secondary toolbars with icons that are specific to that view. Secondary toolbars are located below the main application toolbar, and generally (but not always) on the right side of the screen above the preview pane. Standard secondary toolbar icons, along with their shortcut keys (if any) include the following:

Icon	Name	Shortcut Key	Action
	Insert/Add/Create	Insert	Add or create something new.
	Option menu		Indicate that a menu of options displays when the icon is clicked.
	Delete	Delete	Delete (or archives) a selected item.
	Open	F2 and Ctrl+O	Open a selected item.
	Edit	F2	Edit a selected item.
	Clear		Clear selections made or a text box.
	Note		Enter a note or comment.
	Search	F3	Open the Search dialog.
	Face Sheet		Display the selected patient's face sheet.
	Print	Ctrl+P	Print the document.
	Pull Chart	Ctrl+P	Pull the selected patient's chart.
	Move Up		Move the selected item up in the list.
	Move Down		Move the selected item down in the list.
	Move to the Right		Move the selected item to the pane on the right.
	Move to the Left		Move the selected item to the pane on the left.

Icon	Name	Shortcut Key	Action
	Move to the Top		Move the selected item to the top of the list.
	Move to the Bottom		Move the selected item to the bottom of the list.
	Spell Check		Start spell check.
	Spell Check Options		Select spell check dictionaries and other options.
	Refresh	F5	Include new information in the view.

Right-clicking for pop-up menus

Right-clicking in most panes produces a pop-up menu of options.

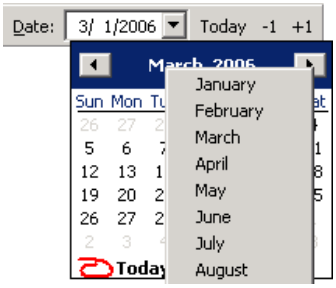


Options with chevrons (›) to the right include secondary menu options. To display them, hover the cursor over the primary option.

Hot keys (when available) display to the right of an options (**Example:** Ctrl+M)

Entering dates

Many contact screens require entering dates. In most cases, the current date displays by default. You can double-click the month, day, or year to highlight it and then type the correct date over the highlighted area ***or*** click the search (…) button to enter the date in a dialog box.



1. **Year** - Click **2006** to display roll bars to change the year.
2. **Month** - Click (Back) or (Forward) to select a different month ***or*** click the name of the month to display a drop-down menu of months.
3. **Day** - The current day is circled in **red**. To select a different date, click it.
4. Click **OK** to save the date.

NOTE: In a text field, you can press **F5** on your keyboard to insert the current date.

Entering phone numbers

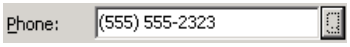
To enter a phone number, do **one** of the following:

- Type the number in the field. The system automatically formats a 7- or 10-digit number when you tab off of it (**Example:** 9191234567 becomes (919) 123-4567) ***or***

- Click the ellipsis button (...) to display a quick entry box.

1. Enter the area code without parentheses.
2. Enter the number without hyphens or spaces.
3. Enter an extension number (if any).
4. Click **OK**.

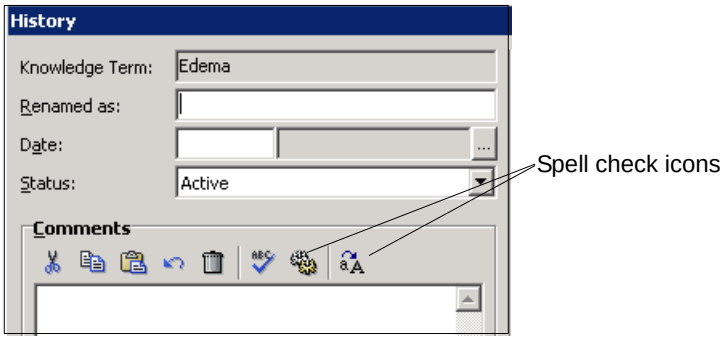
A correctly formatted number displays in the *Phone* field.



Checking spelling

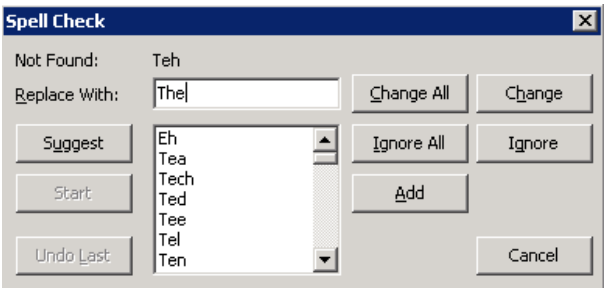
HealthMatics EMR spell checker provides the ability to check spelling in all note/comment boxes and free text fields, using either a standard English dictionary, as well as the ***Stedman's Medical Dictionary***. Dictionaries are stored in files on each workstation, consequently, Spell Check is saved per workstation.

1. From any note or comment box where Spell Check icons are displayed, click .



NOTE: If you have not previously configured your spell check program, a Confirm message appears. Click **Yes** to select the main dictionary and follow the instructions for Configuring spell check on page 12.

2. **IF** Spell Check does not find any misspelled words, click **OK** in the message box that displays the number of words checked.
3. **IF** misspelled words are found, Spell Check displays possible corrections.



Unrecognized spelling displays at *Not Found*.

- **IF** the spelling is correct as is, do one of the following:
  - > To skip over it and continue the spell check, click **Ignore *or***

> To add it to the system's dictionary, click **Add**.

- **IF** the word needs to be corrected, do one of the following:

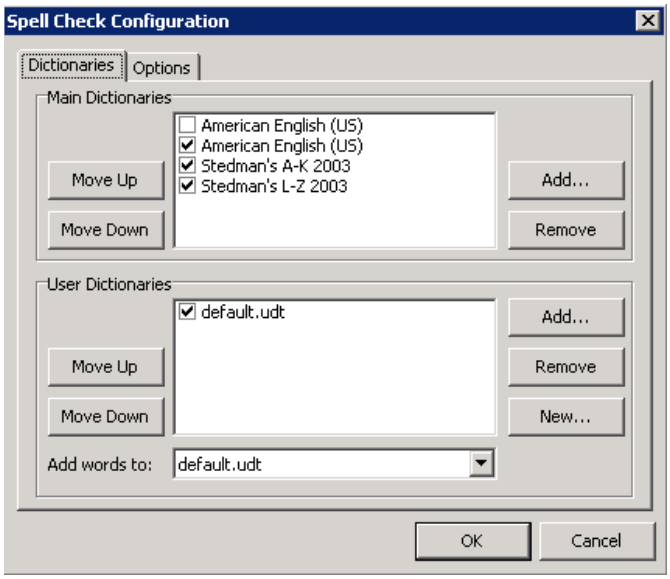
  > Select the correctly spelled word from the list and click **Change** or just double-click it ***or***

  > If the correct spelling is not in the list, at *Replace With*, type the correct spelling in the field and click **Change**.

4. When spell check is complete, click **OK** in the Information box that appears.

Configuring spell check

1. Click (Spell Check Options) to display Spell Check Configuration.At *Main*



Dictionaries, select the boxes of the dictionaries you want your spell checker to use.

NOTE: Select a dictionary and click **Move Up** or **Move Down** to determine the order in which the dictionaries are searched.

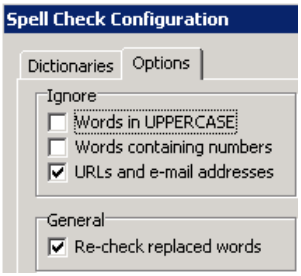
2. At *User Dictionaries*, click *default.udt* for the default.

NOTES
* On the *Dictionaries* tab, you can click **Add** to add main and user dictionaries, and then browse to link to the appropriate resource.

* You can also select a dictionary and click **Remove** to remove main and user dictionaries.

* It is unlikely that you will do either of these. You may, however, add words to *User Dictionaries* while using spell check in the EMR.

3. Click the **Options** tab.



4. In *Ignore*, select boxes as needed to have spell check ignore the items.
5. In *General*, to set Spell Check to recheck words that have been replaced, select *Re-check Replaced Words* and click **OK**.

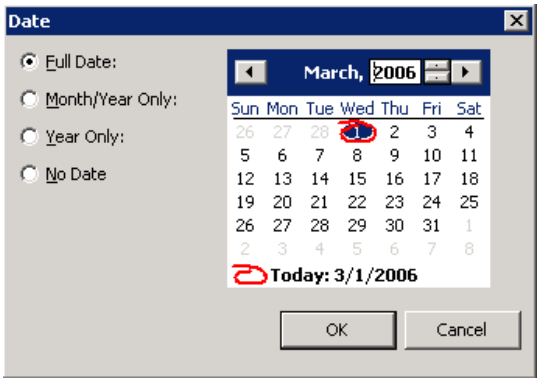
Using pen-based functions

You can enter information quickly and easily using functions within HealthMatics EMR, many of which are designed specifically for pen-based users.

To set dates

You can type in dates or use the calendar function. Here is an example.

1. On the HealthMatics EMR toolbar, tap (Pull a Chart), search for a female patient, and pull the chart.
2. On the toolbar, tap (Vitals).
3. On the secondary toolbar, click (Add Vitals).
4. At *LMP Date*, tap the ellipsis button (...).


Date
Full Date:
Month/Year Only:
Year Only:
No Date
March, 2006
Sun Mon Tue Wed Thu Fri Sat
26 27 28 1 2 3 4
5 6 7 8 9 10 11
12 13 14 15 16 17 18
19 20 21 22 23 24 25
26 27 28 29 30 31 1
2 3 4 5 6 7 8
Today: 3/1/2006
OK
Cancel

5. Tap **Full Date** to display a calendar.
6. Tap the year to display scroll buttons, the month to display a drop-down menu of months, and the date to select it, then click **OK**.

To access the keypad

The on-screen keypad ( ) helps pen-based users enter information. The keypad icon is available in many dialog boxes.

- To change the format of the keypad from the standard style to alphabetical, tap on the bottom-left corner of the on screen keypad:

- To move the keypad, tap the title bar and drag it to another position.
- To enter information at the location of the cursor, tap the appropriate characters.
- To close the keypad, tap the **x** in the upper right corner.

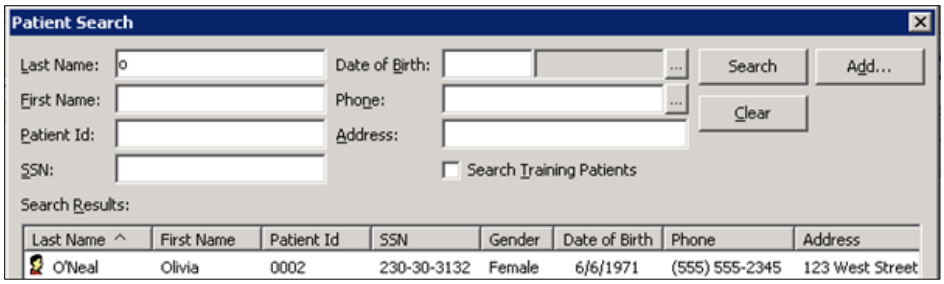
To access the numeric keypad

The numeric keypad is for pen-based users to enter numeric information. HealthMatics EMR must be open with the cursor in a field that requires numeric information.

Patient Search

Throughout the HealthMatics EMR application, you will need to search for patients. When the Patient Search dialog box displays, follow these steps to locate the patient you need:

1. Enter characters in the search fields near the top of the screen and click **Search**.



2. To help locate the patient you need, sort the list that displays by clicking any column name.

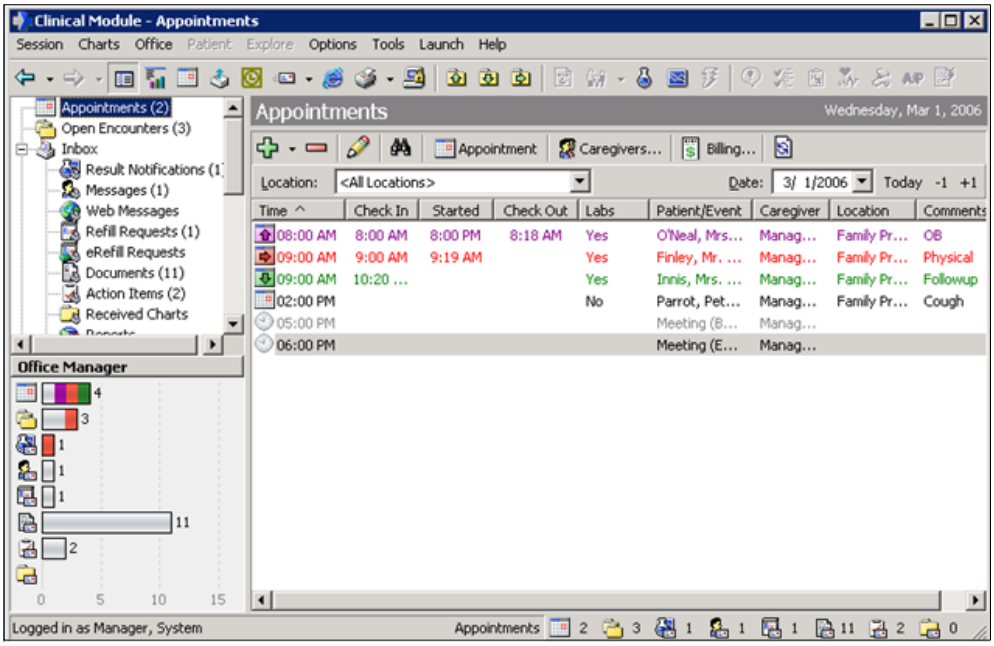
   NOTE: The current sort column is indicated by a chevron ( ) going either up or down, depending upon the sort direction.

3. Select the patient and click **OK**.

Appointments

To display the appointments view in HealthMatics EMR, click (Appointments) on the toolbar, desktop (left pane), Office Manager, status bar, or menu bar (**Office > Appointments**).

Appointments is highlighted in the left pane and a list of appointments for the day displays to the right in the preview pane.



NOTES

- **Practice management systems** - HealthMatics EMR automatically imports appointments that are scheduled in your Practice Management System (PMS). If you do not have any patients scheduled for today, the *Appointments* bar in *Office Manager* does not display.
- **Default schedule displayed** - The schedule for the day lists patients to be seen at the selected *Location* and *Date*.
- **Appointment count** - The Appointment numbers in the left pane and on the status bar represent the total number of checked in and started appointments. Numbers change when data are refreshed ( ).
- **Appointment time columns**
  - > *Time* - Appointment time scheduled
  - > *Check in* - Time patient arrived
  - > *Started* - Time patient was taken to exam room
  - > *Check out* - Time patient checks out
- **Other appointment information**
  - > *Labs* - Displays *Yes* or *No* to indicate if labs were ordered.
  - > *Patient/Event* - Displays name and phone number of patient or event.

> *Caregiver* **-** Displays caregiver scheduled to see patient.

> *Location* - Displays location where patient scheduled to be seen.

> *Comments* - Displays reason for patient visit or description of event if time was blocked.

- **Office manager** - In *Office Manager,* the bar for the current day's appointments is color-coded based on the status of each.
- **Appointment colors** (*Office Manager* and preview pane)

  > **Black** - Appointment is scheduled; patient has not yet checked in.

  > **Green** - Patient has checked in.

  > **Red** - Appointment has started.

  > **Purple** - Patient has checked out.

  > **Gray** - Time is blocked.

- **Entering appointment status times** - To enter the current time and change the appointment status, select the appointment and do one of the following:

  > Right-click the appointment and click either **Check In, Start,** or **Check Out *or***

  > On the secondary toolbar, click **Appointment** and then either **Check In, Start**, or **Check Out**.

  NOTES
  * Clicking **Start** when no *Check In* time is present enters the current time in both *Check In* and *Started* fields.

  * Clicking **Check Out** when no *Check In* or *Started* times are present enters the current time in all three fields.

  * To remove a time entered in error, highlight the appointment, click (Edit Appointment), and **Clear**.

- **Editing appointments** - To edit an appointment status time after it has been entered or to change other appointment information, select the appointment and do one of the following to display the Appointment dialog:

  > Press **F2** on the keyboard ***or***

  > On the secondary toolbar, click (Edit)

- **Office manager** - Appointments remain in the Office Manager stack unless rescheduled (from your PMS) or checked out. When you enter a check-out time, either in HealthMatics or in your PMS, the following things happen:

  > The check out time appears in the *Check Out* column.

  > The appointment item turns purple.

  > The appointment stack/number reduces by one.

- **Viewing appointments by location** - Click the **Location** down-arrow and select the location to view:

- **Viewing appointments by date** - Click the **Date** down-arrow to display a calendar and select the date to view or click -1 or +1 to view the day previous or the day after the selected date. Click **Today** to return to the current date.
- Use secondary toolbar icons to do any of the following:

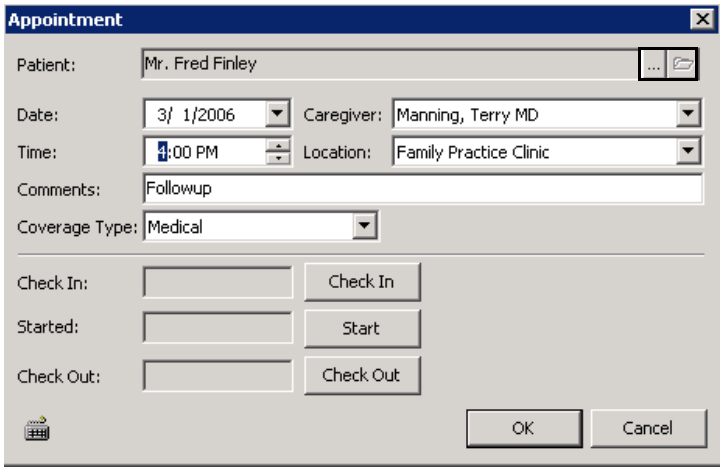
Icon	Name	Action
	Add/Block	• Add an appointment (**Ins**) ***or*** • Block time IF you do not have a Practice Management System (**Ctrl+Ins**).
	Delete (**Del**)	Delete a selected appointment.
	Edit (**F2**)	Edit a selected appointment.
	Search Appointment (**F3**)	Search for a patient's appointments.
	Appointment	• Access Ntierprise Appointment Scheduling, Registration, or Financial Inquiry. • Enter appointment (status) times (see Checking patients in and out on page 18). • Pull charts. • View H&P Reports, Billing Information, Labs, Reminders, or Worklogs.
	Filter Caregivers	Include other caregivers' scheduled patients for the day in your *Appointments* view.
	View Batch Billing Report	Display billing information for all of the current day's scheduled patients (see Displaying daily billing information on page 21).
	Refresh Appointments (**F5**)	Display new information entered into the HealthMatics EMR recently, if you cannot wait until the screen refreshes itself automatically.(see To set desktop defaults on page 109).

Scheduling appointments in HealthMatics EMR

IMPORTANT NOTE! If you have a Practice Management System (PMS), appointment information entered in the PMS overwrites appointment information in HealthMatics EMR. Therefore, make appointments and check patients in and out in your PMS instead of in HealthMatics EMR. If you do **not** have a PMS, follow the steps below:

1. From the HealthMatics EMR desktop, toolbar, or status bar, click (Appointments).

2. Press **Insert *or*** on the secondary toolbar click **> Add Appointment**.



3. Select a patient by doing **one** of the following:

   - **IF** the patient's chart is open (name displays on the application title bar), click (Use Current Chart).
   - **IF** the patient's chart is **not** open, click the *Patient* search button ( ) to locate the patient you need (see Patient Search on page 14).

4. At *Date* and *Time,* accept the defaults, type over them, or click down-arrows to select an appointment date and time.
5. Click the **Caregiver** down-arrow to select the provider that the patient wants to see.
6. Click the **Location** down-arrow to select the location for the appointment.
7. At *Comments*, enter comments about the appointment if desired.
8. Click the **Appt. Type** down-arrow and select the type of appointment if desired.

   NOTE: You can set a caregiver option to display appointment types on the title bar if desired. See To customize the title bar on page 125.

9. Click **OK** to create the appointment.

Checking patients in and out

IF you do **not** have a Practice Management System, to enter check-in information, from the HealthMatics EMR desktop, toolbar, or status bar, click (Appointments).

- **To enter appointment time**

  > Press **Shift** on your keyboard and click in the appropriate column on the appointment line ***or***

  > Highlight the appropriate appointment, right-click, and select **Check In, Start,** or **Check Out *or***

- **To perform other tasks relating to patient appointments**, on the secondary toolbar, click **Appointment** for a drop-down menu.

Icon	Option	Action
	Ntierprise	**IF** you have the Ntierprise Practice Management System, access any of the following: • Appointment Scheduling • Registration • Financial Inquiry
	Check In	Enter the time the patient checks in (**green**).
	Start	Enter the time the appointment starts (**red**).
	Check Out	Enter the time the patient checks out (**purple**).
	Pull Chart	Pull the chart for the selected patient's appointment.
	View H&P Report	View the H&P Report for the selected appointment.
	View Billing Information	View the billing information for the selected patient's appointment.
	View Labs	View the labs for the selected patient's appointment.
	View Reminders	View reminders for the selected patient's chart.
	View Worklog	View contact with the selected patient's chart.

NOTE: Most of these functions can also be accessed by right-clicking anywhere in the right pane of the Appointments view to access a pop-up menu.

Searching for patient appointments

1. From the HealthMatics EMR desktop, toolbar, or status bar, click (Appointments).
2. Press **F3** on your keypad ***or*** on the secondary toolbar click (Search Appointment).
3. Select a patient by doing **one** of the following:
   - If the patient's chart is open click (Use Current Chart).
   - If the patient's chart is **not** open, click the *Patient* search button (...). For instructions, see Patient Search on page 14.
4. To view an appointment, select it and click **Go to**.
   The program scrolls to that date with the selected patient's appointment highlighted.

Changing or editing appointment information

1. From the HealthMatics EMR desktop, toolbar, or status bar, click (Appointments).
2. Select the appointment and do one of the following to display the Appointment dialog box:
   - Press **F2** on your keypad ***or***
   - Right-click and select **Edit Appointment** ***or***
   - Click (Edit) on the secondary toolbar.
3. Make changes as needed and click **OK**.

NOTE: Clearing the *Started* field also clears *Check Out*. Clearing *Check In* clears all three fields.

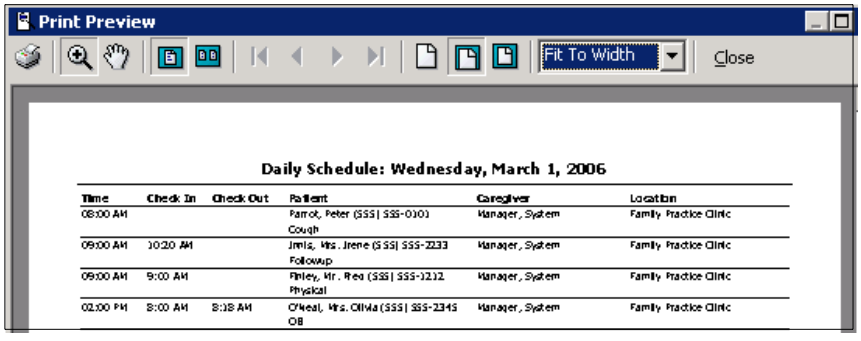
Blocking time on schedules

If you do **not** have a Practice Management System, you can block time on your schedule directly in HealthMatics EMR.

1. From the HealthMatics EMR desktop, toolbar, or status bar, click (Appointments).
2. On your keyboard, press **Ctrl+Insert** ***or***
   on the secondary toolbar, click **> Add Blocked Time**.
3. In Appointment Block, fill in the fields and click **OK**.
   The beginning and ending time for the block display in the schedule.

Printing daily schedules

1. From the HealthMatics EMR desktop, toolbar, or status bar, click (Appointments).
2. If you are printing schedules for multiple locations, click the **Location** down-arrow to select the location.
3. Click the **Date** down-arrow to select the appropriate date.
4. On the toolbar, select **> Daily Schedule** to open Print Preview.



5. Use the toolbar buttons to manipulate the document, if desired, and then click (Print Document).
6. In the Print dialog, select the printer and other information as needed and click **OK**.

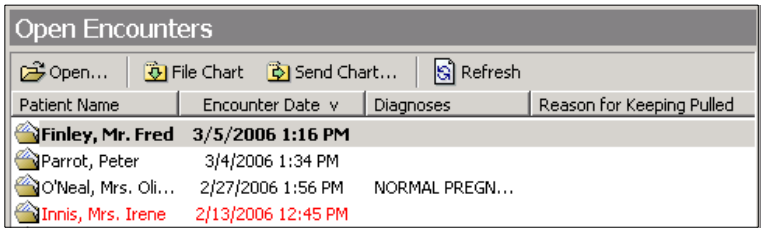
Displaying daily billing information

1. From the HealthMatics EMR desktop, toolbar, or status bar, click (Appointments).
2. On the secondary toolbar, click (View Batch Billing Report) to display billing information available for current day's patients, including billing levels, diagnoses, and plans.

   NOTE: If a patient has been selected in the Appointments view prior to clicking , the billing details list automatically scrolls to the selected patient.
3. Click **Print** to print a list of all patients with billing data entered for the selected day.

Open Encounters

1. To display a list of encounters that have not been signed off, on the status bar, in the left pane of the desktop, or in Office Manager, click (Open Encounters).



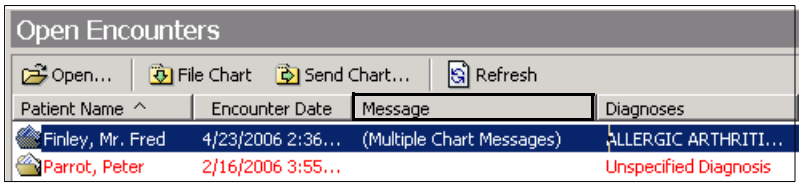
   - Bold - Encounter is from the current date.
   - Black - Encounter is from the past week.
   - Red - Encounter is more than one week old.

2. Select an encounter and, on the secondary toolbar, click icons to do the following:

Icon	Name	Action
	Open Chart (**F2**)	Open the selected chart and view the patient's face sheet.
	File Chart	File the selected chart. **NOTE:** If the History & Physical Report displays, the chart contains new clinical information that must be signed off before it can be filed. If you do not have authority to save H&P reports, send the chart to a caregiver who does.
	Send Chart	Send the selected chart to another caregiver.
	Refresh (**F5**)	Display new open encounters if you cannot wait until screen refreshes itself automatically. (To set Refresh default time, see To set desktop defaults on page 109.)

Outstanding chart messages

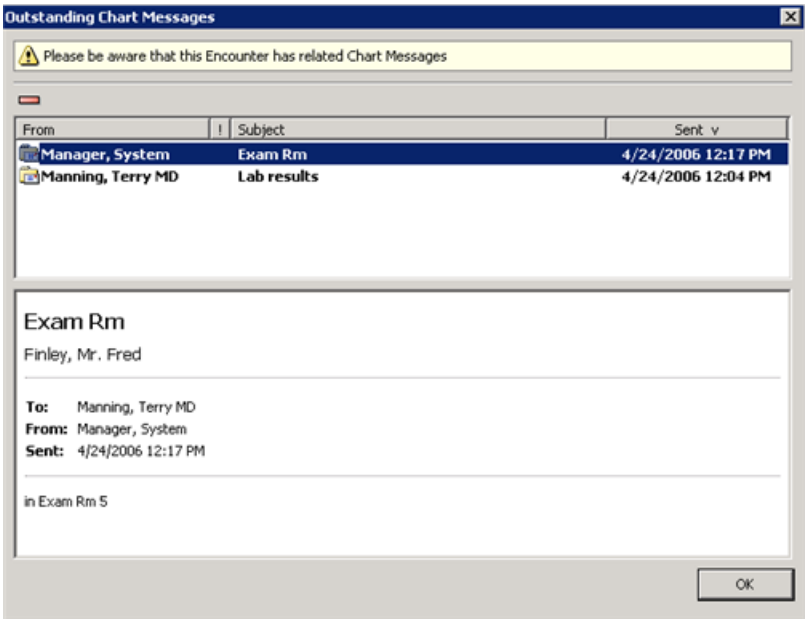
In Open Encounters, the *Message* column provides a quick view of messages sent when one caregiver sends a chart to another.



If there is more than one chart message associated with the encounter, *Multiple Chart Messages* displays in the *Message* column.

1. Select the item and click **Open** to see if any of the chart messages associated with the encounter have content other than a Subject.

- If the message has no content other than a Subject, the chart message deletes automatically when the chart is pulled.
- If the message does have content, the Outstanding Chart Messages dialog appears.



2. After reading the message, click (or press **Delete** on your keyboard) to delete the message and close the dialog ***or*** click **OK** to close the dialog without deleting the message. Chart Reminders (if any) and the patient's face sheet.

NOTES

- Only messages with content appear in the dialog, so even if you saw the *Multiple Chart Messages* subject in your list of open encounters, you may only see one message here.
- The dialog displays all messages associated with the encounter -- not just those sent to you.

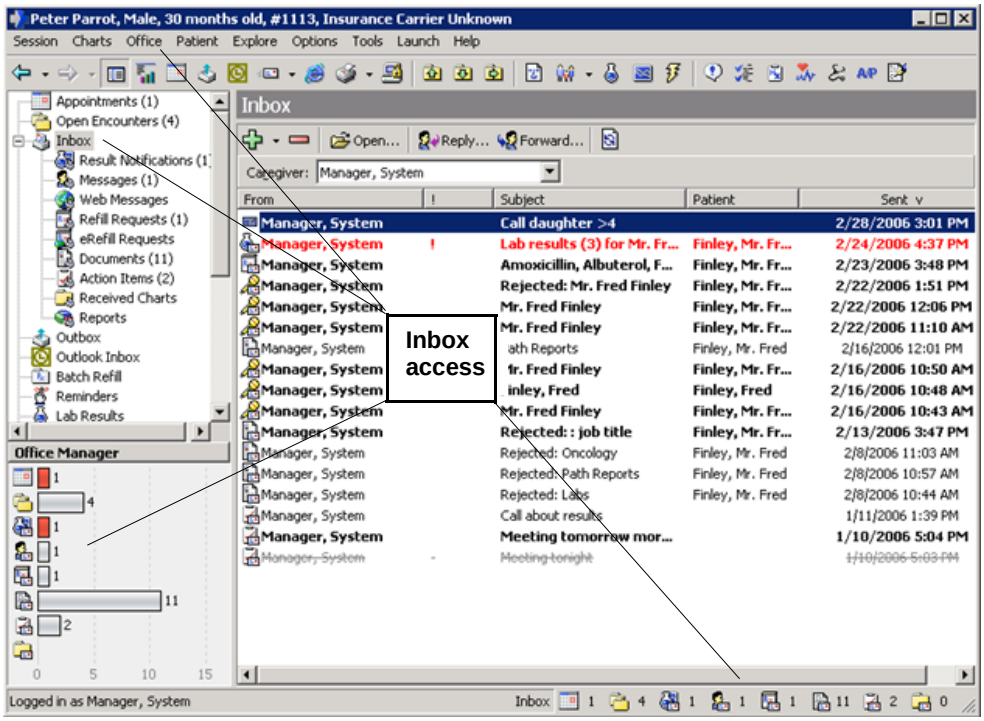
Inbox

Access your HealthMatics EMR Inbox ( ) from the left pane on the desktop ***or*** from the menu bar by selecting **Office > Inbox**.

Filtering inbox items

Filter items in your inbox by clicking any of the following:

- Icons under *Inbox* in the left pane
- Bars in **Office Manager**
- Icons on the status bar



Status bar inbox filters

The status bar is **always** visible, no matter what screen you are on in the EMR. Most caregivers manage their inbox and other workflow from the status bar. The numbers to the right of each icon on the status bar (and the numbers in the left pane under *Inbox* and the bars in *Office Manager*) indicate the number of items of that type that have not been read.

NOTE: If the *Urgent Message Indicator* has been set to flash, the numbers alternate between the number of items awaiting review and the number of items that contain abnormal results ***or*** are designated *High Priority.* (See To set desktop defaults on page 109 for instructions on setting the Urgent Message Indicator.)

You can filter the inbox to view any of the following items:

Icon	Name	Description
	Result Notifications	Notification messages that lab and/or procedure results have been received and are ready for your review (see Result Notifications on page 29).
	Messages	Patient and mail messages sent to you by other staff members (see Messages on page 32).
	Web Messages	Messages sent from patients via the practice website (see Web Messages on page 43) **NOTE:** Web Messages only displays if the practice has purchased HealthMatics Access and it has been set up and synchronized (refer to the ***Access Manual***).
	Refill Requests	Refill requests received from patients by phone (see Refill Requests on page 44.
	eRefill Requests	Refill requests sent to you electronically from pharmacies (see eRefill Requests on page 55) **NOTE:** eRefill Requests only displays if the practice has purchased ePrescribe and it has been enabled (**Launch > Administration Module > System Options > ePrescribe**).
	Documents	Transcription or scanned documents sent to you for approval (see Documents on page 70).
	Action Items	Reminders set for yourself or received from other caregivers (see Action Items on page 77).
	Received Charts	Charts sent to you for review, prior to a patient encounter or received from a PA or other caregiver requesting review (see Received Charts on page 80).
	Reports	Messages sent to you about report results that require your action (**Example:** patients who need to be called to set up screening tests).

NOTES

- High priority items display in **red** (when not selected) have a red exclamation point in the priority (**!**) column.
- Scroll to see all of the columns in your inbox or manipulate column size by grabbing and moving the bars between column headings.
- Items that have been “marked done” but have not been deleted from your inbox display in gray with a line through them.

Inbox item icons

Each item in your inbox is preceded by one of the following icons:

Icon	Item
	Patient message
	Mail message
	Lab results
	Procedure results
	Patient education
	Transcription
	Voice transcription
	Scanned document
	Web message

Performing inbox tasks

1. On the toolbar or left pane of the HealthMatics EMR desktop, click (Inbox).
2. Click secondary toolbar icons to do any of the following:

Icon	Name	Description
	New (**Insert**)	Display a menu of items you can create.
	Delete Message (**Delete**)	Delete a selected message (see Deleting messages from the inbox on page 27).
	Open (**Ctrl+O**)	Open a selected inbox item.
	Reply (**Ctrl+R**)	Reply to a selected message.
	Forward (**Ctrl+F**)	Forward a selected message to another caregiver.
	Review (**Ctrl+V**) Approve (**Ctrl+A**) Complete (**Ctrl+C**)	Review a selected document or result. Approve a selected refill request.
	Reject (**Ctrl+R**)	Reject a selected refill request.
	Refresh (**F5**)	Display new items sent recently if you cannot wait until the screen refreshes itself automatically (see To set desktop defaults on page 109).

Deleting messages from the inbox

To delete messages without opening them

Many (but not all) items can be deleted from your inbox without opening them. To do so, select the item, click on the secondary toolbar, and **Yes** to confirm.

You can delete the following types of messages this way:

- Result notifications (messages attached to lab and procedure results)
- Messages (both mail and patient)
- Action items
- Received charts

You must open **and** take additional action before you can delete *Refill Requests, eRefill Requests* and *Documents* (transcription and scanned) items from your inbox. Therefore, you do not need to worry about deleting them by mistake.

To delete inbox messages after opening them

After opening a message in HealthMatics EMR, you can delete it by doing any of the following, depending upon the type of message:

Icon	Name	Description
	Result Notifications	Mark the patient's test results *Reviewed* to delete the message from your desktop automatically and place a note in the patient's chart (see Reviewing lab results on page 178 and Reviewing procedure results on page 191).
	Mail Messages	Take action on the item if necessary, click **Delete** and **Yes** to confirm (see Viewing the list of messages on page 32).
	Patient Messages	Take action on the item, click **Delete**. If you choose to save the patient message to the chart, you are prompted to confirm the delete (see Responding to patient messages on page 40).
	Web Messages (Displays if you have HealthMatics Access)	Take action on the item, click **Delete**. If you choose to save the patient message to the chart, you are prompted to confirm the delete (see Web Messages on page 43).
	Refill Requests	Approve the refill and either file the chart or send it to the refill manager. The message deletes from your desktop automatically and a note is placed in the patient's chart (see Approving or rejecting refill requests on page 48.
	eRefill Requests (Displays if you have ePrescribe)	Approve the refill and either file the chart or send it to the refill manager. The message deletes from your desktop automatically and a note is placed in the patient's chart (see eRefill Requests on page 55)

Icon	Name	Description
	Documents	Review the document and **Approve** it (which files it in the chart) or **Reject** it (which returns it to the transcriber or scanner. The message deletes from your inbox automatically (see Approving or rejecting documents on page 71).
	Action Items	Take action on the item, click **Delete** and **Yes** to confirm (see Responding to action items on page 79).
	Received Charts	Click **Pull Chart** and **Yes** to confirm (see Received Charts on page 80).
	Reports	Take action on the item if necessary, click **Delete** and **Yes** to confirm (refer to the ***Reporting Module*** manual for additional information).

Viewing other caregivers' inboxes

IF other caregivers have granted you access to their inboxes, you can view their inboxes from your desktop (see Editing grants on page 129).

1. On the toolbar or left pane of the HealthMatics EMR desktop, click (Inbox).
2. Click the **Caregiver** down-arrow and select a caregiver.

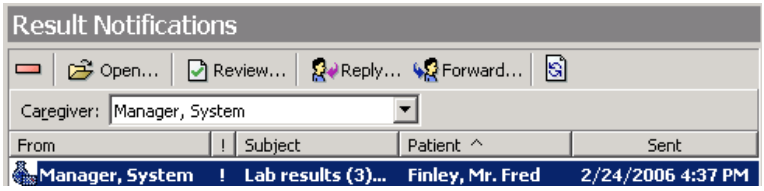
Result Notifications

Result Notifications are system-generated messages sent to you when lab, procedure, or other results are available in the patient's chart and awaiting your review.

For general instructions for using HealthMatics EMR windows, see Windows, Panes, and Other Tools on page 8.

Viewing notification messages and results

1. To display a list of messages announcing lab, procedure, and "additional" results awaiting review, click (Result Notifications) on the status bar or left pane of the HealthMatics EMR desktop.



   Icons preceding each item in the list designate its type of results.

Icon	Description
	Lab results
	Procedure results
	Additional results such as referrals and authored text

2. **Sort** notification messages by clicking on any column head.
   A carat on the column heading indicates the sort column Patient (up or down).

Heading	Action
From	Sort by the caregiver who sent the notification message.
!	Place high priority items (results containing abnormal values) at the top of the list.
Subject	Sort by type of results (lab, procedure, referral) waiting for review. **NOTE:** The number in parentheses shows the number of results ready for review for that patient.
Patient	Sort by patient name.
Sent	Sort by date and time the notice was sent.

3. **Filter** results by clicking the **Caregiver** down-arrow to see another caregiver's result notification messages **IF** you have access to his/her inbox (see Editing grants on page 129).

4. **Select** a notification from the list and, on the secondary toolbar, click icons (or right-click) to do any of the following:

Icon	Name	Action
	Delete (**Delete**)	Delete the notification if you do not need to mark the results *Reviewed*. **NOTE:** This does not delete the results.
	Open (**Ctrl+O**)	Open the selected message and view the results.
	Review (**Ctrl+V**)	Review lab results and mark them *Reviewed*. You can also annotate and publish results to the website with comments (see Reviewing lab results on page 178 and Reviewing procedure results on page 191).
	Reply to Notification (**Ctrl+R)**	Send a Patient Message to a caregiver about the selected results.
	Forward (**Ctrl+F**)	Forward the results notification to a caregiver other than the original sender.
	Refresh (**F5**)	Display new lab and procedure results sent to you recently if you cannot wait until the screen refreshes automatically. (To set Refresh default time, see To set desktop defaults on page 109.)

For additional information about Result Notifications, see Lab Results on page 175, Processing referrals on page 195, and Procedure Results on page 188.

See also Viewing other caregivers' inboxes on page 28.

Determining who receives message notifications

When your lab interface is set up, you can configure how result notifications are sent to caregivers. Your interface team will discuss this with you and set the parameters you select.

This is the most common configuration for practices with bi-directional lab interfaces:

1. **Ordering caregiver** - Result notification messages are sent to the Ordering Caregiver.

   NOTE: If someone other than the ordering caregiver documents the order on the A/P screen, their name defaults as the Ordering Caregiver. To assure that the result notification message goes to the appropriate caregiver, on the Create Requisition screen, click the **Ordering Caregiver** down-arrow and select the appropriate caregiver who should receive the Result Notification (see Creating lab requisitions from assessment/plan on page 300).

2. **"cc" caregiver** - **IF** the ordering caregiver information is not available, then the system looks for a "cc" caregiver, which is designated by the laboratory. (**Example:** An EMR physician refers a patient to a specialist who orders the test, and indicates that the results should also go to the EMR physician who referred the patient.)

3. **Default** - **IF** no information is available for either the ordering caregiver or a cc caregiver, the result notification message goes to the person designated by the practice to be the *Default* caregiver for message notifications. This default caregiver can be the system administrator or any other caregiver that the practice assigns when the interface is set up.

NOTE: The designation, “Attending Caregiver,” is not used to determine message notifications. Typically, Attending Caregiver defaults to the person placing the order on the Create Requisition screen.

Blocking result notifications

You can block result notification messages from your inbox by doing the following:

1. Log in to the **Administration Module** and, in the left pane, select **Caregivers**.
2. Select the caregiver name and press **F2** ***or*** click **> Properties**.
3. In the *Classification* box, select **Block Result Notifications** and click **OK**.

Messages

Messages are user-generated messages, either personal or patient-related, sent to you by other caregivers.

For general instructions for using HealthMatics EMR windows, see Windows, Panes, and Other Tools on page 8.

Viewing the list of messages

1. **To list patient and mail messages** on your desktop, click (Messages) on the status bar ***or*** in the left pane of the HealthMatics EMR desktop.

   NOTE: The number next to the icon (1) on the status bar and stack shows the number of **unopened** messages. Unopened messages appear in bold.

   - Indicates a Patient message containing patient information that can be saved to the chart.

   - Indicates a Mail message that does not contain patient information. These are messages that can be sent from one caregiver to another, similar to email. They cannot be saved to a patient's chart.

2. Use the secondary toolbar icons or right-click for a drop-down menu to manipulate your messages. For a description of those functions, see Performing inbox tasks on page 26.

See also Viewing other caregivers' inboxes on page 28.

Entering data on tabs

NOTE: See also Notes on page 344.)

Both *Mail* and *Patient Messages*, include four tabs for entering the message: Text, *Image, Voice*, and *Import*. The tab containing the message displays an icon (Text) to indicate that it contains data.

Text

Text is the most commonly used method of entering a message. On the *Text* tab, type the text of the message. All *Text* message boxes include a toolbar with icons similar to those available in Microsoft Word®

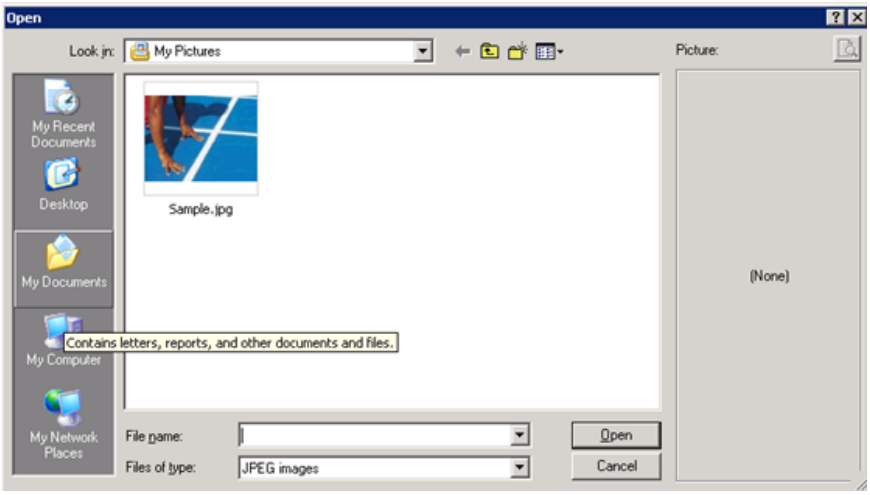
Icon	Name	Action
	Load from File	Click to upload document from file into message text box.
	Save to File	Click to browse to directory and save message as file.
	Cut	Highlight text and click to cut and place it on clipboard.
	Copy	Highlight text and click to copy it to clipboard.
	Paste	Place your cursor where you want text to be located, and click to paste it in.
	Undo	Click to undo last action taken.
	Clear	Click to clear selected text.
	Spell Check	Click to check spelling of text message.
	Spell Check Options	Click to open Spell Check Configuration dialog to set up spell checker. Select one or more dictionaries (including ***American*** and ***Stedman***) and select options to ignore, such as words in upper case.
	Auto-Replace Options	Click to Add, Edit, Delete, Print, or Copy auto-replace entries (see Editing auto replace text on page 131).

Image

You can add images to your messages. Click the **Image** tab, and do the following:

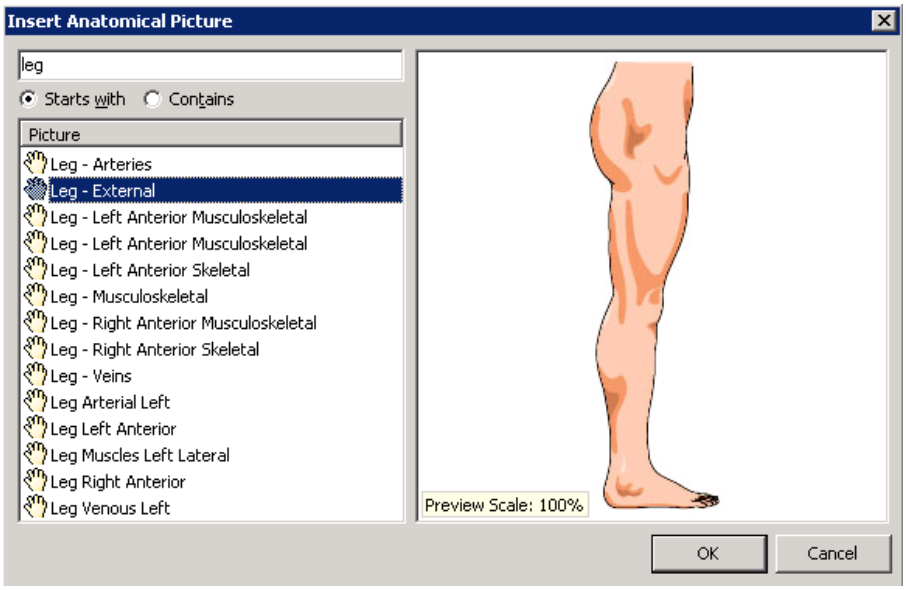
1. On the toolbar, click the **down-arrow** and select the repository for the image (**File System, Library**, or **Import Photo**) ***or*** you can just click (not the arrow) to default to the *Library*.

- **File system**



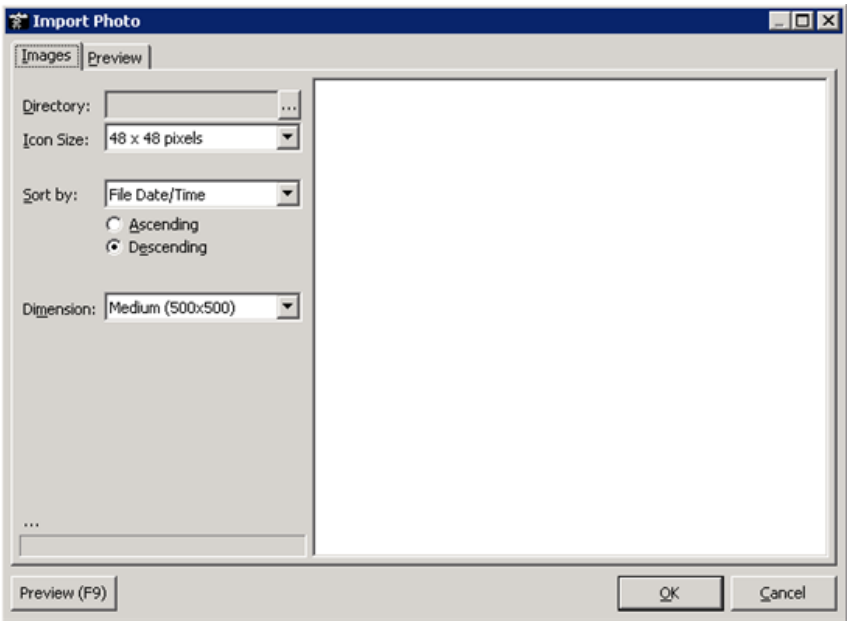
Search for the image from the files available on your PC.

- **Library**



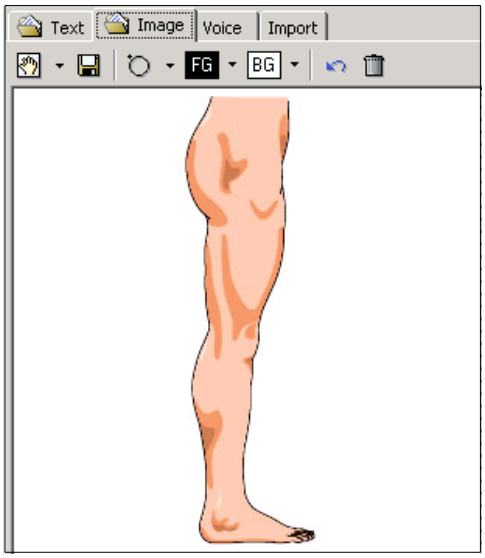
Type a few characters in the search field to automatically scroll to the appropriate image.

- **Import photo**



Search for the image from the directories available from your workstation.

2. Select the image and click **OK** (or **Open**) to include the image in the message. The data icon displays on the Image tab (Image) and the image appears on the screen.



NOTE: Scroll down if necessary to view the image.

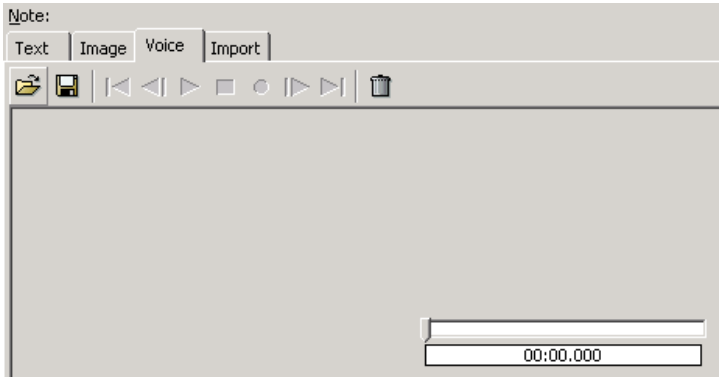
3. Click (Drawing Tool) to drop-down a menu of items you can use to draw on the image:

Icon	Name	Action
	Pencil	Draw free-hand lines.
	Line	Draw straight lines.
	Rectangle	Draw rectangles.
	Filled Rectangle	Draw rectangles that are filled in.
	Circle	Draw circles.
	Filled Circle	Draw circles that are filled in.
	Text	Open a Text Properties dialog and type text that you want to appear on the image, click **OK**, and then click on the image where you want the text to appear.

NOTES
* To change the color of the lines or the fill color, click FG and select the desired color.
* To undo the last change made to the image, click .
* To clear the Image tab, click .
* To save the image to a file, click .

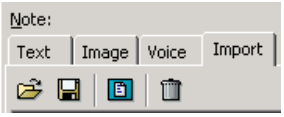
Voice

If your hardware includes sound cards and microphones (and is fat client), you can dictate notes of up to 5 minutes in length. To do so, click the **Voice** tab and use the buttons as you would on a regular tape recorder (see Entering voice messages in notes on page 349).



Import

You can include files in your messages such as scanned or other documents that have been saved to your hard drive. To do so, click the **Import** tab.



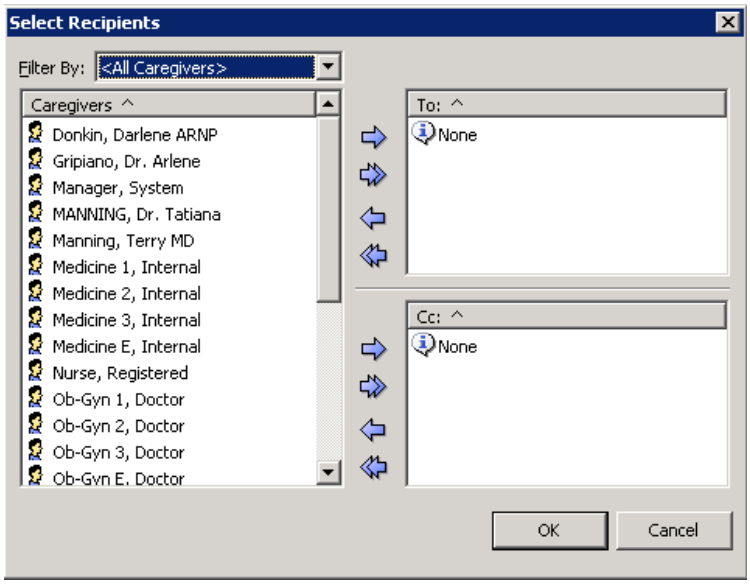
Click (Load from File), browse to select the desired file and click **Open**.

Sending mail messages

Mail messages provide a fast, convenient way to communicate with one or more caregivers in your practice about things that do not pertain to patients.

NOTE: You cannot attach **mail** messages to patient charts. Use **patient** messages for items that need to be documented in charts (see Sending patient messages on page 39). You can also attach Microsoft Outlook® emails to patient charts (see Outlook Inbox on page 85).

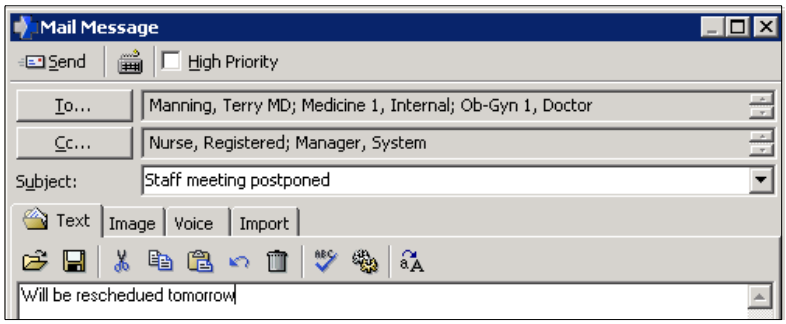
1. To create a new mail message, do **one** of the following:
   - From the HealthMatics EMR toolbar, click (Send) **> Send Mail Message *or***
   - Click (Messages) on the status bar or the left pane of the HealthMatics EMR desktop to access the Messages view, and then press **Insert** on your keyboard or click (New Message) **> Mail Message**.



2. Click the **Filter By** down-arrow and select a filter to narrow choices if desired, and then select message recipients by doing **one** of the following:
   - Double-click each recipient's name in the *Caregivers* list ***or***
   - Select the recipient's name and click next to the *To* or *Cc* box ***or***
   - Click to send the message to all caregivers.

NOTES
* Select multiple names by pressing **Ctrl** *or* **Shift** keys while clicking names.
* To remove names from the recipient list, select a name and click .
* To clear all names from the *To* or *cc* list, click .

3. After selecting all recipients, click **OK**.



4. At *High Priority*, click to make the message high priority if desired.
   High priority messages display in the recipients' inboxes in red font.

5. At *Subject*, type a subject ***or*** click the down-arrow to select one from the list.

   NOTE: To add subjects to drop-down lists, refer to *Message Subjects* in the ***Administration Module*** manual.

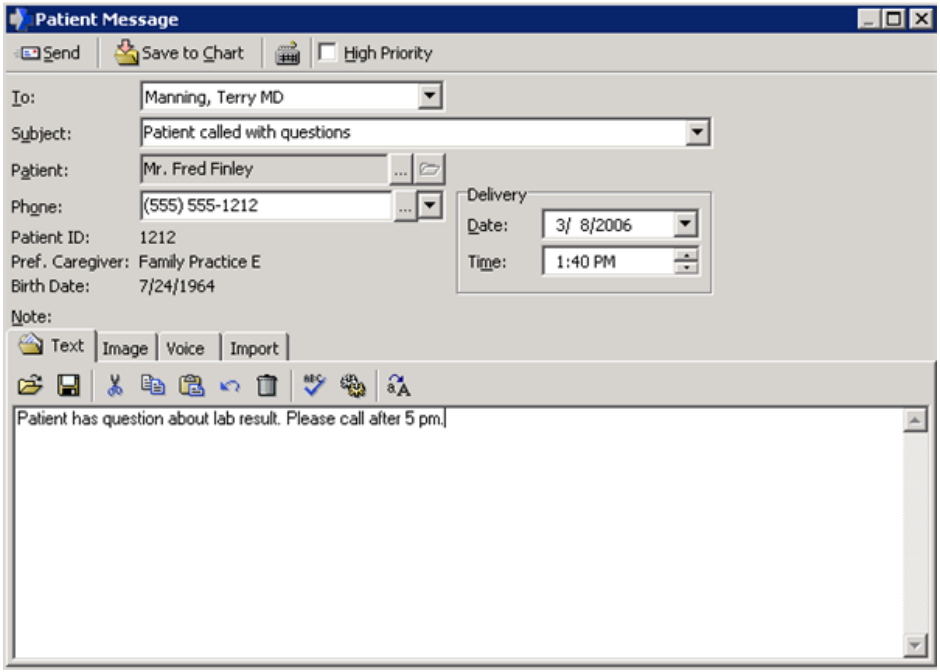
6. Click the appropriate tab and enter text, image, dictated, or imported information (see Entering data on tabs on page 32).

7. Click **Send**.
   The message appears in the recipients' inboxes and in your outbox (until the recipients open it).

Sending patient messages

When a patient calls with questions for a caregiver about a problem, treatment, or other issue, you can document the message and save it to the patient's chart in HealthMatics EMR.

1. On the HealthMatics EMR toolbar, click (Send) **> Send Patient Message *or*** from the *Inbox* or *Messages* view, click **> Patient Message**.



NOTE: When a patient is selected, *Patient ID, Preferred. Caregiver*, and *Birth Date* are pulled from the database.

2. If the message is urgent, select **High Priority**.
3. Click the **To** down-arrow and select **one** caregiver from the list.
4. Enter a *Subject* **or** click the down-arrow to select one.

   NOTE: To add additional subjects to drop-down lists, go to **Launch > Administration Module > Message Subjects**. (For instructions, refer to the ***Administration Module*** manual.)

5. At *Patient*, do one of the following:
   - If the message is about the current patient that you have open on your desktop (name on the title bar), click (Use Current Chart) ***or***
   - Click the search button (...) and select one (see Patient Search on page 14).
6. At *Phone*, the patient's home phone number displays.
   If the caregiver needs to call the patient at a different number, do **one** of the following:
   - Type the correct phone number ***or***
   - Click the **Phone** down-arrow to select the number from those on file ***or***

- Click the ellipsis button (...) to enter a phone number and click **OK**.

7. At *Delivery*, accept the defaults to have the message delivered immediately ***or*** change the *Date* and/or *Time* to indicate when the message should be sent to the caregiver's inbox.
8. Enter a message on any of the four tabs (see Entering data on tabs on page 32).
9. To permanently save the message to the patient chart now, click **Save to Chart** and **Yes** to confirm.

   NOTES
   * A Confirm message appears if you are not sending the message to the patient's primary caregiver. Click **Yes** to notify the primary caregiver that a message has been saved to their patient's chart.

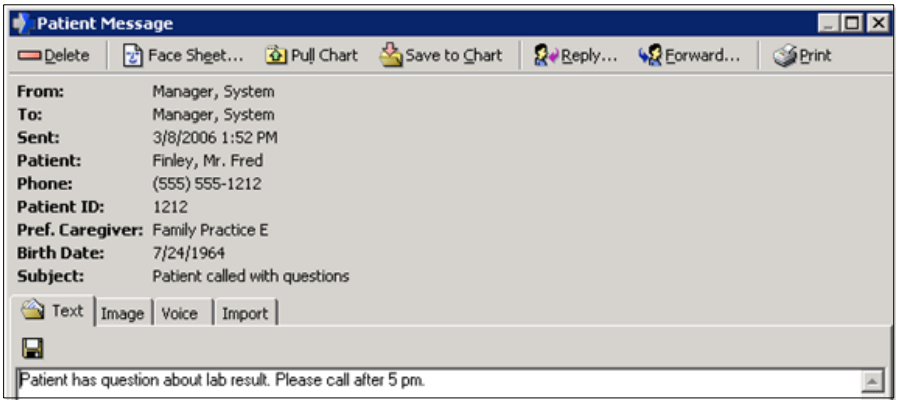
   * You can skip the **Save to Chart** step and allow the recipient to save the message to the patient's chart once a response is entered.
10. Click **Send**.
    The message displays in recipient's inbox (and your outbox until opened by recipient).

Responding to patient messages

When you receive a patient message, you can view it, reply to it, forward it to another caregiver, print it, pull the patient's face sheet or chart, and save the message as a permanent part of the patient's chart.

1. On the status bar or left pane of the HealthMatics desktop, click (Messages).

   NOTE: The Messages view displays patient messages ( ) and mail messages ( ).
2. Select a patient message from the list that displays and do any of the following:
   - **To view the message**, double-click it or select it and click **Open**.



   > **Delete** - Delete the message by clicking **Delete** and **Yes** to confirm.

   > **Face sheet** - Click to open the patient's face sheet in a separate dialog box. When you are through viewing the face sheet, close it to return to the message for further action.

> **Pull chart** - Click to **close the message** and go to the patient's chart. A dialog box asks if you want to delete the message on your desktop. Click **No** if you want to be able to view the message again after you pull the chart. The Messages view closes and the patient's face sheet displays.

> **Save to chart** - Click to save the message to the patient's chart. Type a comment or response at the top of the text box (if desired) and click **Save to Chart** again and **Yes** to delete the original message.

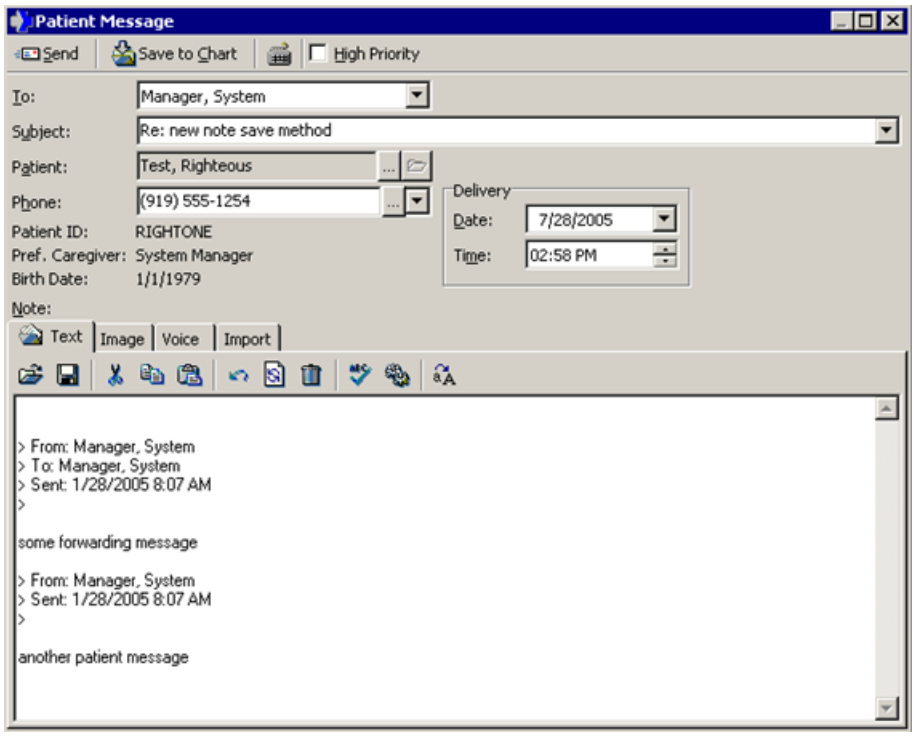
NOTE: If neither you nor the recipient is the patient's primary caregiver, a message displays asking if you want to notify the primary caregiver that a message was saved to the patients chart.

> **Reply** - Click to reply to the message.

> **Forward** - Click to forward the message to another caregiver.

> **Print** - Click to display the message in Print Preview; click to print.

- **To reply to the sender** - From the secondary toolbar in the *Message* view (or the open message), click **Reply**.



> At *To*, accept the original sender's name or click the down-arrow to change it.

> Enter a reply on the *Text, Image, Voice*, or *Import* tab.

NOTE: On the *Text* tab, space is made for the reply at the top of the text box, and the original message displays below it.

> To permanently save the message and response to the chart, click **Save to Chart**. and **Yes** to confirm.

NOTE: If you are not the patient's primary caregiver, another Confirmation message may appear. If you would like to notify the primary caregiver about action taken, click **Yes**; otherwise, click **No**.

> Click **Send** and **Yes** to confirm.

- **To forward the message to another caregiver**, from the secondary toolbar (or the open message), click **Forward**:

  > Click the **To** down-arrow to select the recipient.

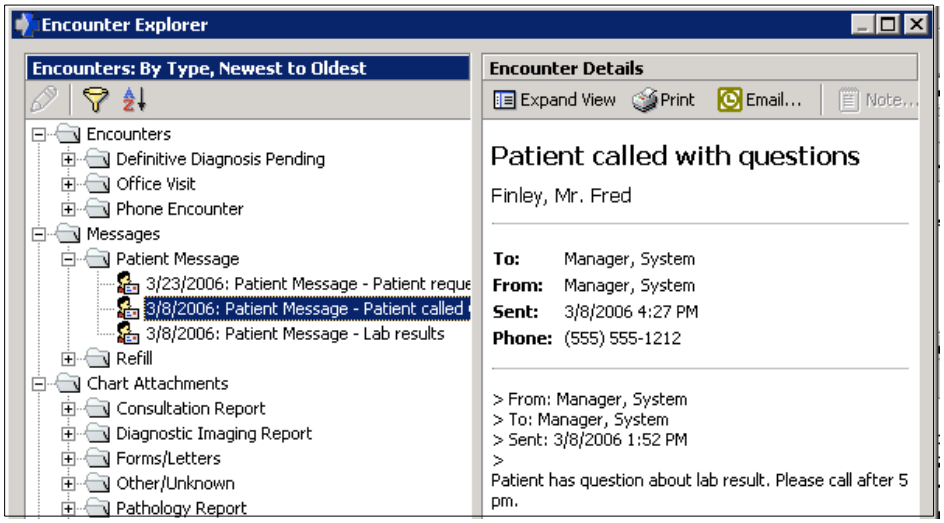
  > Enter a message on any tab (*Text, Image, Voice*, or *Import*).

  > Click **Send** and **Yes** to confirm.

- **To save the message as a file on your computer**, click (Save to File) on a tab to save the message to a directory on your computer.

Viewing patient messages saved to charts

1. Pull the patient's chart and, in the *Encounters* pane, click (View Encounter).
2. Sort ( ) the items *By Type*.
3. Expand the *Messages* folder, and select the message to display it in the preview pane to the right.



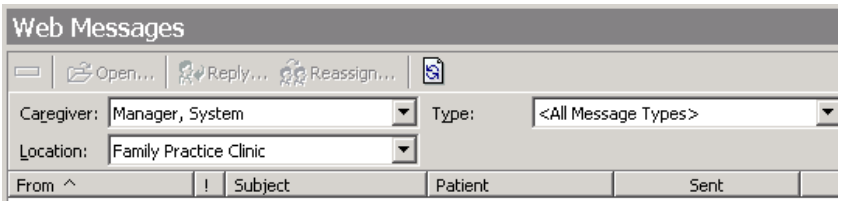
4. Click the **X** in the upper right corner to close the Explorer window.

Web Messages

Web Messages are patient-generated messages, sent to you by patients from the practice website using the Internet. You can open them, reply to them, or reassign them to other caregivers for action.

For general instructions for using HealthMatics EMR windows, see Windows, Panes, and Other Tools on page 8.

To list web messages on your desktop, in the left pane of the Healthmatics EMR desktop, click (Web Messages).



See also Messages on page 32 for additional information about processing messages and Viewing other caregivers' inboxes on page 28.

Use the secondary toolbar icons or right-click for a drop-down menu to manipulate your messages. For a description of those functions, see Performing inbox tasks on page 26.

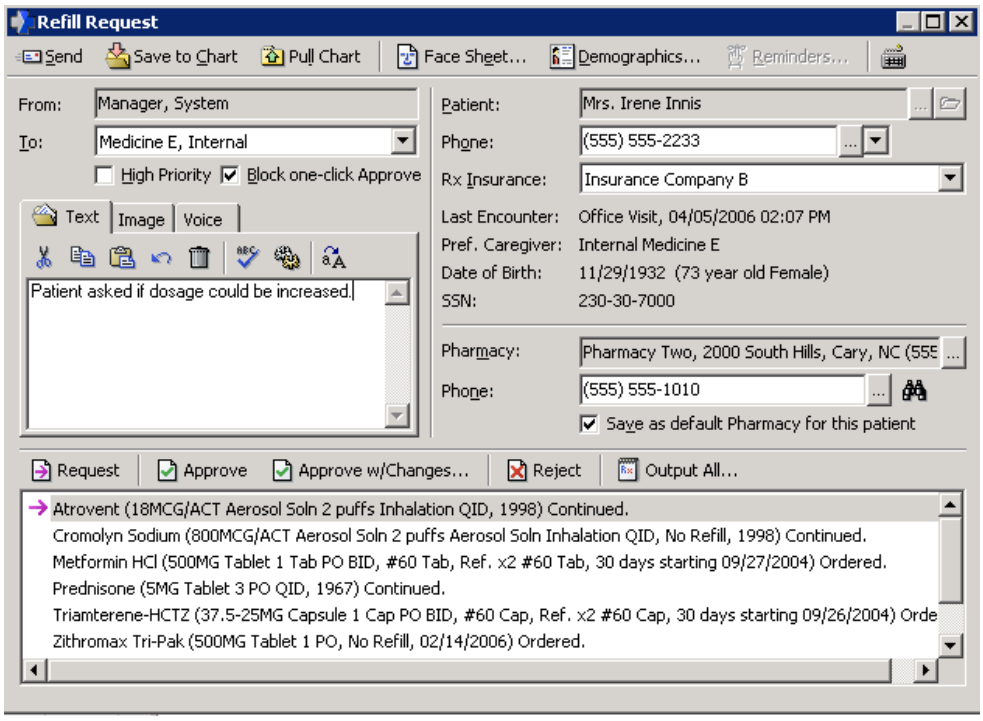
- **To locate messages**, click the **Caregiver** and **Location** down-arrows to filter the list.
- **To open a web message**, select it and do one of the following:
  - > Double-click it ***or***
  - > Press **Ctrl+O** ***or***
  - > Click Open on the secondary toolbar ***or***
  - > Right-click and select **Open**.
- **To reply to a web message**, select it and click **Reply** on the secondary toolbar. For additional instructions, see Responding to patient messages on page 40).
- **To reassign a web message**, select it and click **Reassign** on the secondary toolbar.

Refill Requests

Refill Requests are caregiver-created messages alerting you to a patient's request for a medication refill.

Sending refill requests

1. Access the refill request dialog box from any of the following places:
   - **Desktop > Inbox** or **Outbox >** down-arrow **> Refill Request**
   - **Desktop > Batch Refill >** (New Refill Request)
   - **Toolbar** (Send) **> Send Refill Request**
   - **Desktop > Refill Requests** or **status bar** (Refill Request) **>** (New Refill Request)



2. **To select the patient and verify insurance/pharmacy information:**
   - At *Patient*, click (Use current chart) ***or*** to search for a patient.
   - Verify the patient's phone number.

     NOTE: The home phone from Demographics displays automatically. For other phone numbers in the database, click the **Phone** down-arrow. You can also type the phone number in the field, if the correct number is not displayed, or click the search button to enter a new one.
   - At *Rx Insurance*, accept the patient's preferred carrier entered in Demographics ***or*** click the down-arrow to select another.
   - View the following information as needed:

> *Last Encounter* displays date, time, and type of the selected patient's last encounter. (Excludes transcription, messages, refill requests, and chart attachments.)

> *Pref caregiver* displays the patient's preferred caregiver from Demographics.

> *Date of birth* displays the patient's date of birth and current age.

> *SSN* displays the patient's Social Security number if it is in the database.

> Click to view the patient's face sheet.

> Click to view the patient's demographic information.

> Click to view *Reminders* placed on the patient's chart. (If there are no reminders on the chart, this function is disabled.)

3. **To verify/select pharmacy information:**

   - At *Pharmacy*, verify that the pharmacy displayed is the correct one ***or*** click to search for a pharmacy, and, if not in the database, click to create it for the current refill.
   - At *Phone*, verify that the number displayed is correct ***or*** if it is not in the database, enter a phone number for the current refill ***or*** click to look up the pharmacy number.

     NOTES
     ***** Changes made in the *Pharmacy* and *Phone* fields are for the current refill request only. To change the data in Demographics, select **Save as default Pharmacy for this patient**.

     * The medications listed in the bottom pane display the complete sig for the patient's most recent active and inactive medications.

4. **To request the medication(s):**

   - From the list at the bottom of the screen, select the medication and click (Request). A purple arrow displays in front of the medication.
   - Select additional medications as appropriate, clicking **Request** for each one individually.

     NOTE: Active medications are prioritized and sorted alphabetically on the Refill Request screen:

     * First - Medications that have been *Requested, Approved*, or *Rejected* display first in the list.

     * Next - The remaining active medications that have not been requested display next in the list, sorted alphabetically by name. (Medications with a status of either *Ordered* or *Continued* are considered active.)

     * Last - Inactive and discontinued medications that have not been requested display last in the list, sorted alphabetically by name.

5. **To send the refill request to the approving caregiver:**
   - Click the **To** down-arrow and select the approving caregiver from the list.

     NOTE: The caregiver name defaults to the primary caregiver on the patient's Demographics screen as soon as you add a patient name.
   - Select **High Priority** for refills that are urgent.
     The refill request will display in red in the caregiver's inbox.
   - Select **Block one-click Approve** to cause the Medication dialog box to open automatically, which forces the caregiver to review prescription details before approving the refill.

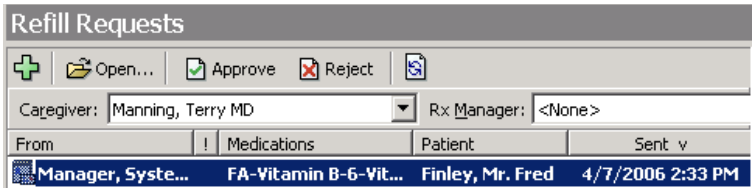
     NOTE: When deselected, the caregiver can approve the refill by selecting message and clicking (Approve) on the secondary toolbar without opening the Medication dialog box to view details. If *Block one-click Approve* is selected, the refill message on the desktop displays in italics.
   - Add an optional message on any tab (*Text, Image, Voice*) and enter information.
   - Click **Send** to send the refill request to the caregiver for approval.

NOTE: The **Save to Chart** and **Pull Chart** buttons are for approving caregiver's use. If you click **Pull Chart**, the Refill Request dialog box closes, and the chart opens. If you click **Save to Chart** before the refill has been approved, a Warning displays, telling you to approve or reject the request.

Viewing refill requests

For general instructions for using HealthMatics EMR windows, see Windows, Panes, and Other Tools on page 8.

1. **To access refill requests sent to you for approval**, on the status bar or left pane of the HealthMatics EMR desktop, click (Refill Requests).



   NOTE: The number next to refill request icon 1 on status bar and in the left pane indicates number of refill requests awaiting action.

2. **To sort refill requests**, click column headings:

Heading	Description
From	Sorts items by users who sent the messages.
!	Sorts items by importance with refill requests marked *High Priority* at the top.

Heading	Description
Medications	Sorts items by medication name.
Patient	Sorts items by patient.
Sent	Sorts items by date and time received.

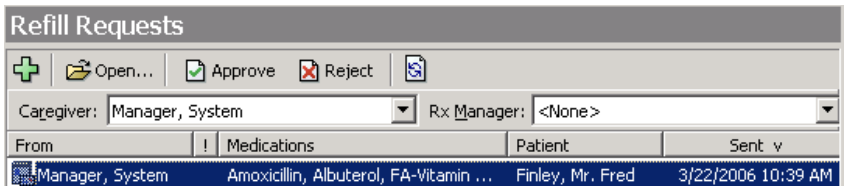
3. **To assign a refill manager**, click the **Rx Manager** down-arrow and select the name of the person assigned to call, fax, or transmit prescriptions to pharmacies.
4. **To approve refill requests sent to other caregivers** (**IF** you have been granted access), click the **Caregiver** down-arrow and select the other caregiver's name.
5. **To perform other functions**, click the icons on the secondary toolbar ***or*** right-click for a drop-down menu to perform the following tasks:

Icon	Name	Action
	New Refill Request (**Insert**)	Create a new refill request (see Refill Requests on page 44).
	Open (**Ctrl+O**)	Select a refill message and click **Open** to view it.
	Approve Refill Request (**Ctrl+A**)	Select the refill and click to *Approve* it (see Approving or rejecting refill requests on page 48). **NOTES** • The approved refill request goes automatically to the person designated as *Rx Manager*, to be called or faxed to pharmacy, or printed. • You must have the appropriate Function Access.
	Reject Refill Request (**Ctrl+R)**	Select and/or open a refill request from the list and click to reject it. **NOTES** • Rejected requests go automatically to the person designated as the *Rx Manager* to notify the patient. • You must have the appropriate Function Access.
	Refresh Refill Requests (**F5**)	Display new information entered into the database recently (see To set desktop defaults on page 109).

NOTES: Refill request messages are removed from your inbox when you approve the refill, or when the *Rx Manager* clicks **Called In, Fax**, or **Print** in Batch Refill ***or*** clicks **File in Chart**.

Approving or rejecting refill requests

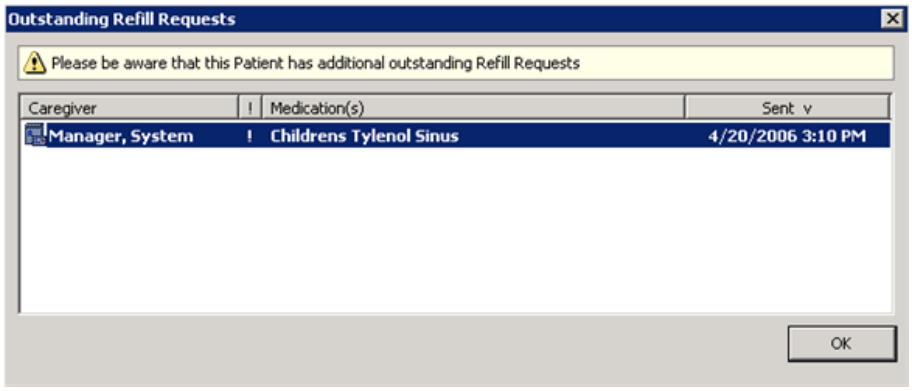
1. From the status bar or left pane of the HealthMatics EMR desktop, click (Refill Requests).



2. To assign a person to process the approved refill request, click the **Rx Manager** down-arrow and select that caregiver.

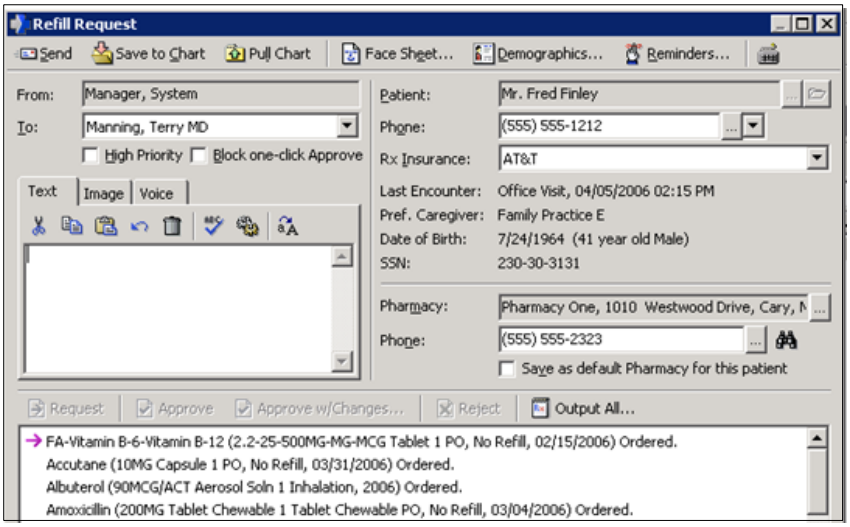
3. Double-click a refill request ***or*** select it and click **Open** on the secondary toolbar.

   NOTE: If the patient has outstanding refill requests, the following dialog box displays:



   Click **OK** to continue and display Refill Request.

   .



NOTE: In Refill Request, you can use the secondary toolbar icons to do any of the following:

Icon	Name	Action
	Send	Send refill request to another caregiver for approval or to the Rx Manager for processing.
	Save to Chart	Document the refill request in the Encounters pane on the patient's face sheet. Also add it to history in the Medications pane. **NOTES** • If a caregiver approves the refill and clicks **Save to Chart** without first printing, faxing, or marking it called in (in Batch Refill), on the *Encounters* pane of the patient's face sheet, the refill request displays a status of *Filed*. • If an approved refill is sent to output, but the caregiver does not click **Save to Chart**, on the patient's face sheet, the refill is noted under the *Revision History* in the *Medications* pane, but it is not listed under *Refills* in the *Encounters* pane sheet and the refill message remains in the caregiver's inbox. To remove the message, open the Refill Request, select the medication (preceded by the outline of a green check), and click **Save to Chart**.
	Pull Chart	Close Refill Request without saving any changes and open the patient's chart.
	Face Sheet	Open the patient's face sheet to view the patient's problem list or medication history. Click the **X** in the upper right corner of the face sheet to return to the refill request.
	Demographics	Open the Demographics dialog to view or edit the patient's demographics, insurance policies, emergency contacts or picture. Click the **X** in the upper right corner of the dialog to return to the refill request.
	Reminders	Open the Reminders dialog to view (or add) chart reminders for the patient. Click the **X** in the upper right corner of the dialog to return to the refill request.

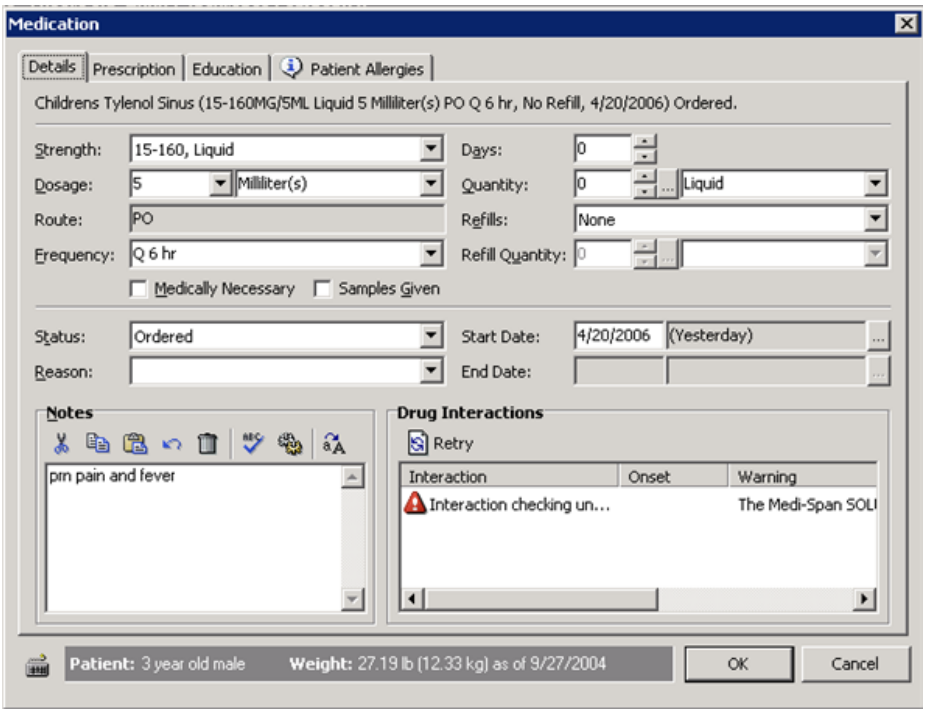
4. From the list of medications at the bottom of the screen, select a medication that has been requested (), and then click **one** of the following:

Button	Action
Approve	Change the status (and icon) from *Requested* to *Approved* .

Button	Action
Approve w/Changes	Change the status from *Requested* to *Approved* and open the Medication dialog box to view and/or edit details for the prescription, or to access the *Prescription, Education*, and/or *Patient Allergies* tabs.
Reject	Mark the refill rejected. If desired, enter instructions to the *Rx Manager* in the *Text* box (**Example:** Please ask patient to come in) and then click **Reject** to change the status from *Requested* to *Rejected* ✕.

NOTE: A Warning box may display interaction information. If so, review the information and click **OK**.

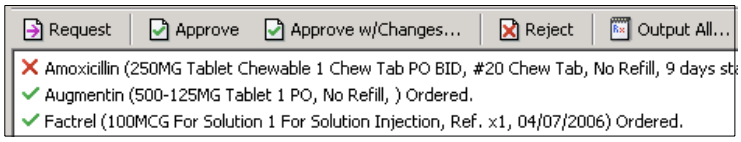
5. If the Medication detail dialog box displays, you can do any of the following:



- **Details tab** - Enter or change ordering details if needed.
- **Prescription tab** - Click to select a template and print, fax, or transmit (if you have these functions) the prescription immediately.
- **Education tab** - Click to print drug information for the patient.
- **Patient allergies tab** - Click to display patient allergies and manifestations.

  NOTE: If no allergies are listed in History for the patient, then the *Patient Allergy* tab does not display.

- Click **OK** to return to the Refill Request screen.


Request
Approve
Approve w/Changes...
Reject
Output All...
Amoxicillin (250MG Tablet Chewable 1 Chew Tab PO BID, #20 Chew Tab, No Refill, 9 days st
Augmentin (500-125MG Tablet 1 PO, No Refill,) Ordered.
Factrel (100MCG For Solution 1 For Solution Injection, Ref. x1, 04/07/2006) Ordered.

NOTE: Refill requests remain in the caregiver's inbox until approved, rejected, sent to output and either the caregiver or Rx manager clicks **Save to Chart**.

6. Process the refill request by doing **one** of the following:

- **Send** - Click to send the approved/rejected refill(s) to the *Rx Manager* (or the caregiver who created the request, if an Rx Manager has not been designated):

  > The approved/rejected refill messages appear in the Rx Manager's (or original sender's) inbox and in the Batch Refill window until the Rx Manager (or original sender) calls, faxes, or transmits it to the pharmacy, or prints it for the patient, and files the request in the chart.

  > The patient's face sheet displays the following message in the *Medication History* pane: *Recorded <date> <time> by <caregiver>, Office Visit*.

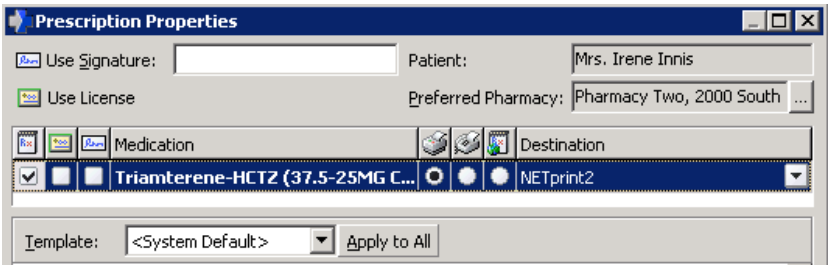
- **Output all** - Click (Output All) to open the Prescription Properties dialog (see Using prescription properties on page 51) where all approved prescriptions can be printed, faxed, or transmitted electronically with electronic signatures (if that functionality has been purchased).

Using prescription properties

See also Approving or rejecting refill requests on page 48.

1. To process prescription refills for a patient, access Prescription Properties from any of the following four places:

- **Refill Request > Output All**
- **Batch Refill > Output**
- **A/P >** (on toolbar) **> Draft > A&P Prescriptions** (checkbox) **> OK**
- **H&P Report > Sign-Off > A&P Prescriptions > OK**
- **Face sheet >** (on Medications toolbar)



- **Use signature** - Enter password for signatures and ePrescribe if required in **Administration Module > Site Settings**.

- **Use license** - Displays and explains the icon in the checkbox below, which you can select to include the approving caregiver's license on the prescription.
- **Preferred pharmacy** - Displays the patient's default pharmacy (from Demographics). Click the search button at the end of this field to make changes.
- **Template** - Select a prescription template for the highlighted medication. Licenses are selected as follows:
  - > If the selected prescription template is the <System Default>, which has no state association, then the ordering caregiver's default state license is used.
  - > Otherwise, the prescription template's associated state is used to select the caregiver's license. If the ordering caregiver does not have a license defined for that state, then no license information is included in the prescription.
- **Apply to all** - Click to apply the selected template to all medications.

2. Use the icons described in the table below to perform tasks as needed.

Columns	Action
	Select all prescriptions to process ***or*** click to select individual prescriptions in this column to process. **NOTE:** Medications preceded by the icon are locked for editing elsewhere in the application
	Apply your DEA license number to all (unlocked) prescriptions listed ***or*** click individual boxes to selectively apply your number.
	Apply your electronic signature to all (unlocked) prescriptions listed ***or*** click individual boxes to selectively apply your signature. **NOTE:** Bitmap signatures must be loaded for each caregiver in **Administration Module > Caregivers > Signature**.
Medication	List all of the patient's prescriptions awaiting refills. **NOTE:** When accessing Prescription Properties from the patient's face sheet, a search button displays after the medication. Click this to open the Medication dialog if you need to make changes.
	Select all (unlocked) prescriptions for printing ***or*** click individual boxes to selectively print. **NOTE:** If the default printer does not display or needs to be changed, click the search button at the right of the *Destination* field and select a printer.
	Select all (unlocked) prescriptions for faxing ***or*** click individual boxes to selectively fax prescriptions to pharmacies. **NOTE:** This only works if the prescription is not for a controlled substance and you have purchased Faxpress.

Columns	Action
	Select all (unlocked) prescriptions for electronic transmittal ***or*** click individual boxes to selectively transmit prescriptions to pharmacies. **NOTE:** This only works if it is not a controlled substance and ePrescribe is installed.
Destination	Display printer, pharmacy, etc. where prescription will be sent. If the information does not display or needs to be changed, click the drop-down arrow or search button to the right. Select your printers in **Administration > My Output Defaults** (on toolbar) **> Prescriptions *or*** (from the menu bar) **Options > Edit Output Defaults**. Pharmacies default to the preferred pharmacy or the last used pharmacy on the medication

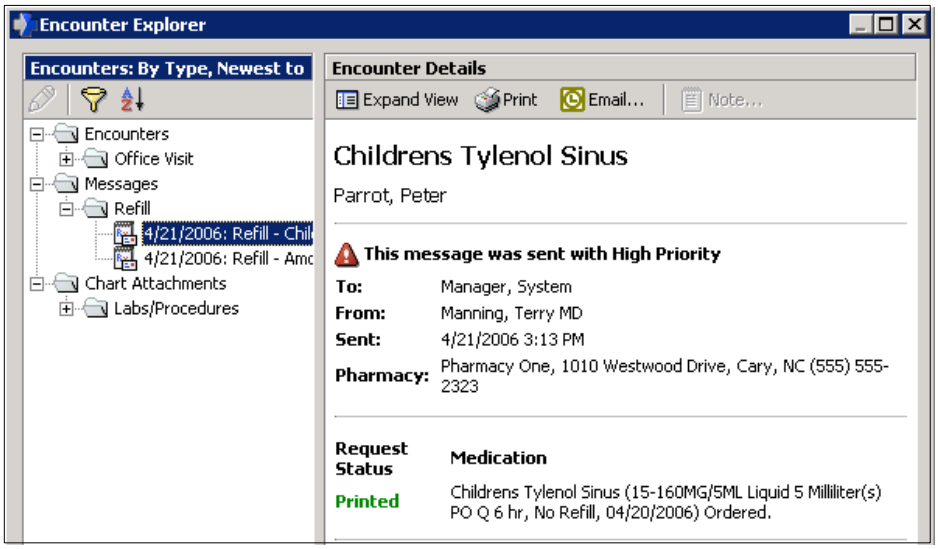
3. Click **OK** to process the output and return to the Refill Request dialog box.

   NOTE: The refills sent to output are preceded by the outline of the green check icons ( ) to indicate that the refills have been processed.

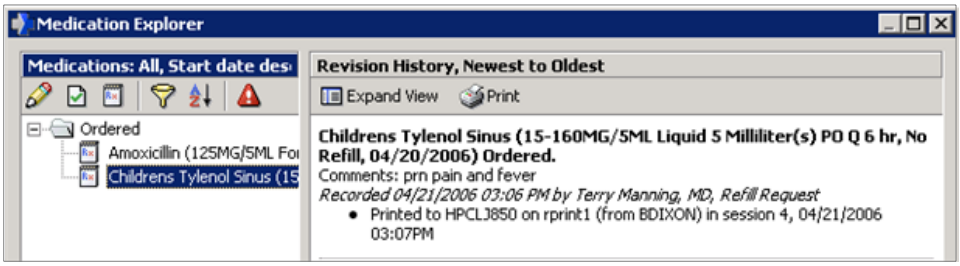
4. Select the medication and click **Save to Chart** to save the refill request to the patient's face sheet and remove the refill message from your inbox.

Refill request details are documented on the patient's face sheet in both Refill Requests from the *Encounters* pane and in *Revision History* in the *Medications* pane.

Encounter Explorer > Messages > Refill



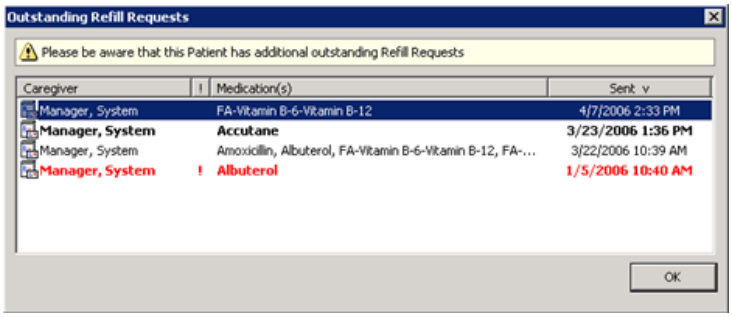
Medication Explorer > Ordered


Medication Explorer
Medications: All, Start date des
Revision History, Newest to Oldest
Expand View
Print
Ordered
Amoxicillin (125MG/5ML For
Childrens Tylenol Sinus (15
Childrens Tylenol Sinus (15-160MG/5ML Liquid 5 Milliliter(s) PO Q 6 hr, No Refill, 04/20/2006) Ordered.
Comments: prn pain and fever
Recorded 04/21/2006 03:06 PM by Terry Manning, MD, Refill Request
Printed to HPCLJ850 on rprint1 (from BDIXON) in session 4, 04/21/2006 03:07PM

Displaying outstanding refill requests from patients

To see all outstanding refill requests for a patient, follow the steps below.

1. From the HealthMatics EMR toolbar, click (Send) **> Send Refill Request**.
2. Click the **Patient** search button ( ) and double-click a patient.
   If the selected patient has any outstanding refill requests, Outstanding Refill Requests displays the medication.


Outstanding Refill Requests
Please be aware that this Patient has additional outstanding Refill Requests
Caregiver
Medication(s)
Sent
Manager, System FA-Vitamin B-6-Vitamin B-12 4/7/2006 2:33 PM
Manager, System Accutane 3/23/2006 1:36 PM
Manager, System Amoxicillin, Albuterol, FA-Vitamin B-6-Vitamin B-12, FA-... 3/22/2006 10:39 AM
Manager, System ! Albuterol 1/5/2006 10:40 AM
OK

   This is a read-only box.
3. Click **OK** to close the box and do **one** of the following:
   - **IF** the refill has **not** already been requested, continue creating the request and send it to the caregiver.
   - **IF** the refill **has** already been requested, click the **X** in the upper right corner of the Refill Request dialog box to cancel.

NOTE: If the patient's chart is open for a current encounter, when you click to select the current patient for the refill request, after you click **OK** in the Warning message (stating the patient's chart is currently being changed in an active visit), an Outstanding Refill Requests message may also appear. Click **OK** again to open the Refill Request dialog box.

eRefill Requests

NOTE: eRefill Requests are only available for practices that have installed ePrescribe. This product allows you to send new prescriptions and receive refill requests (except narcotics) electronically over the SureScripts network (if it is available in your area).

eRefill Requests are pharmacy-generated messages alerting you to a patient's request to the pharmacy for a medication refill.

To prescribe electronically, you must set a caregiver up as a SureScripts user and enter a SureScripts Provider ID (SPI ID) in the **Administration Module**. You must also enter a NCPDP ID for each pharmacy.

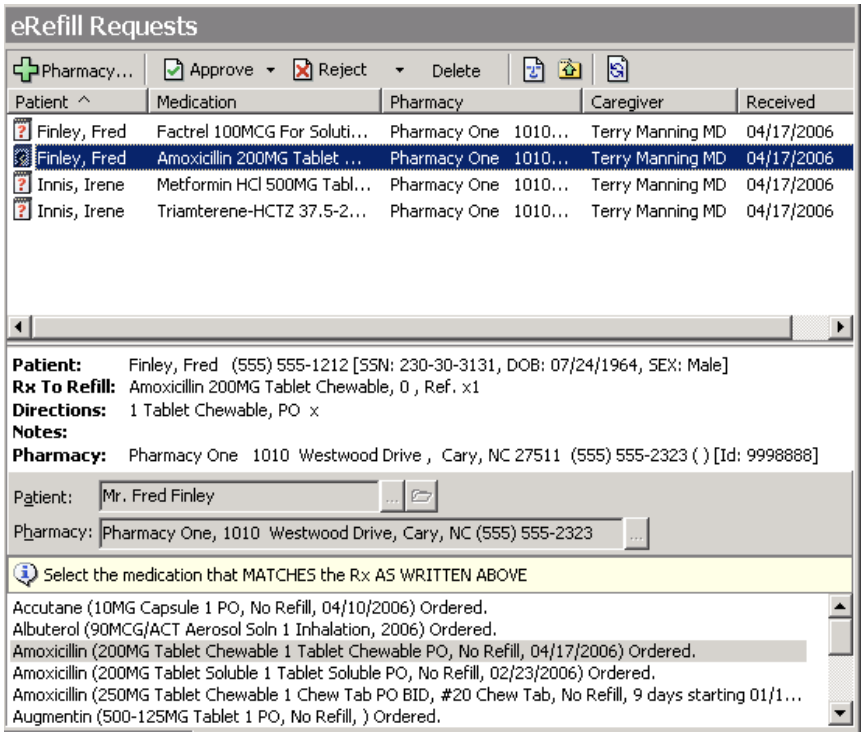
- **Prescribing agents** - Users granted access to eRefill requests work on behalf of the caregiver that receives an eRefill request from the pharmacy. When the eRefill request is returned to the pharmacy, the SPI of the original provider along with the caregiver name is placed in the response message. Assigning a prescribing agent allows the user, as well as the caregiver to see or address the eRefills. Once processed by either, the eRefill disappears.
- **Outgoing messages** - Outgoing messages, such as new prescriptions and refill responses, transmit from HealthMatics EMR to pharmacies through the ePrescribe Gateway across secure, confidential networks directly to the SureScripts server.
- **Incoming messages** - Incoming messages, such as refill requests, queue up on the Gateway and are polled periodically by ePrescribe Synchronization, which can be run from HealthMatics EMR Administration -- either as a scheduled task or manually run on demand.
- **Matching** - Caregivers then match patient and pharmacy, if needed, and manually match the medication in the refill request to a medication in the patient chart. Caregivers with the appropriate passwords can approve or reject refill requests.

  NOTE: No values need to be reconciled for requests you are rejecting.
- **Biometric authentication** - The ability to send electronic messages can be further regulated through the use of a biometric authentication fingerprint scanner device. A third party vendor provides this software solution.

Viewing eRefill requests

Providers with SureScripts SPI IDs and caregivers granted access to a SureScripts provider inbox, can access *eRefill Requests*. A caregiver can assign one or more other caregivers as their *Prescribing Agents*, who can approve and reject eRefill requests on their behalf (see To assign prescribing agents for caregivers on page 66).

1. In the left pane of the HealthMatics EMR desktop ***or*** from the **Office** menu option, select **eRefill Requests** to display a list of eRefill Requests for you and for those who have set you up as a prescribing agent.


eRefill Requests
Pharmacy...
Approve
Reject
Delete
Patient
Medication
Pharmacy
Caregiver
Received
Finley, Fred
Factrel 100MCG For Soluti...
Pharmacy One 1010...
Terry Manning MD
04/17/2006
Finley, Fred
Amoxicillin 200MG Tablet ...
Pharmacy One 1010...
Terry Manning MD
04/17/2006
Innis, Irene
Metformin HCl 500MG Tabl...
Pharmacy One 1010...
Terry Manning MD
04/17/2006
Innis, Irene
Triamterene-HCTZ 37.5-2...
Pharmacy One 1010...
Terry Manning MD
04/17/2006
Patient: Finley, Fred (555) 555-1212 [SSN: 230-30-3131, DOB: 07/24/1964, SEX: Male]
Rx To Refill: Amoxicillin 200MG Tablet Chewable, 0 , Ref. x1
Directions: 1 Tablet Chewable, PO x
Notes:
Pharmacy: Pharmacy One 1010 Westwood Drive , Cary, NC 27511 (555) 555-2323 ( ) [Id: 9998888]
Patient: Mr. Fred Finley
Pharmacy: Pharmacy One, 1010 Westwood Drive, Cary, NC (555) 555-2323
Select the medication that MATCHES the Rx AS WRITTEN ABOVE
Accutane (10MG Capsule 1 PO, No Refill, 04/10/2006) Ordered.
Albuterol (90MCG/ACT Aerosol Soln 1 Inhalation, 2006) Ordered.
Amoxicillin (200MG Tablet Chewable 1 Tablet Chewable PO, No Refill, 04/17/2006) Ordered.
Amoxicillin (200MG Tablet Soluble 1 Tablet Soluble PO, No Refill, 02/23/2006) Ordered.
Amoxicillin (250MG Tablet Chewable 1 Chew Tab PO BID, #20 Chew Tab, No Refill, 9 days starting 01/1...
Augmentin (500-125MG Tablet 1 PO, No Refill,) Ordered.

2. Select a patient in the upper pane to display the details of the eRefill request in the pane below.

NOTES

- Sort items by clicking column headings.
- Icons display before each request:

Icon	Description
	The request must be matched with a patient and/or pharmacy in the reconciler pane at the bottom of the screen before it can be approved.
	The patient and pharmacy are matched. Select the medication in the pane at the bottom of the screen to approve the eRefill.

- In the eRefill Request screen, you can use secondary toolbar icons to do any of the following:

Icon	Name	Action
	Pharmacy (**Insert**)	Add a pharmacy for the selected refill request.
	Approve (**Ctrl+A**)	Approve a selected eRefill request. • **Approve** - Approve the refill as is. • **Approve with changes** - Display Approve With Changes dialog box, in which you can indicate the number of approved refills and insert a *Note to pharmacy*.
	Reject (**Ctrl+R**)	Reject a selected eRefill: • **Reject** - Reject the selected eRefill. • **Reject, Send New Prescription** - Reject the selected eRefill, and display Medication Search dialog box to select a new medication.
	Delete	Delete a selected eRefill.
	Face Sheet (**Ctrl+F**)	Display a selected patient's face sheet. Click the **X** in the upper right corner to close the face sheet and return to eRefill Request.
	Pull Chart (**Ctrl+P**)	Close eRefill Request and pull the selected patient's chart.
	Refresh Refill Requests (**F5**)	Update the screen with the most current eRefills if you cannot wait for the screen to refresh automatically.

Manually matching eRefill requests

Medication matching must be manually performed for each eRefill request. If the prescription from the pharmacy does not match any of the medications in the patient medication list, the eRefill Request should be rejected.

However, in a case where a patient new to the practice is on a maintenance drug and the pharmacy sends an eRefill request to the caregiver, if the medication is not ordered in the chart yet, the caregiver can pull the chart, add the medication, and then approve the refill.

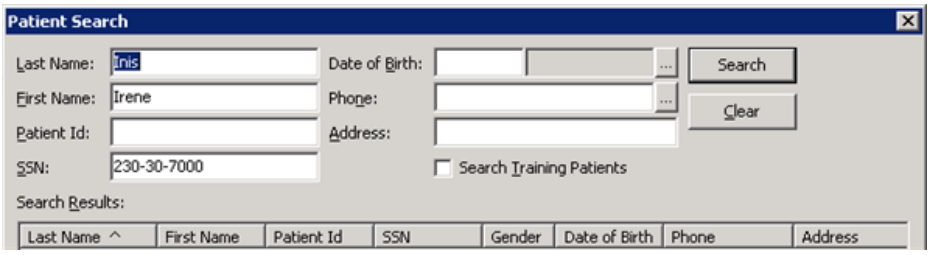
1. Access **eRefill Requests** (see Viewing eRefill requests on page 56).
2. Select an eRefill Request in the upper pane to display the prescriptions details and matching information from the HealthMatics EMR database in the pane below.

   NOTE: In most cases, the patient name and pharmacy are automatically matched, but either one, or both, may not be.

To match patients

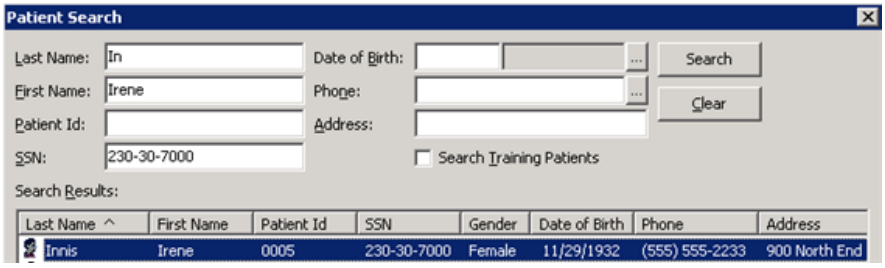
If a pharmacy misspells the patient name or there are multiple patients with the same name and the pharmacy did not include enough information to distinguish among them, the system cannot match the patient name. No medications are listed in the bottom pane for unmatched patients.

1. With an eRefill request selected, click to use the current patient ***or*** click the **Patient** search button ( ).



   Values supplied by the pharmacy display in the search fields.

2. Change or remove the values as needed and click **Search** to broaden the search.



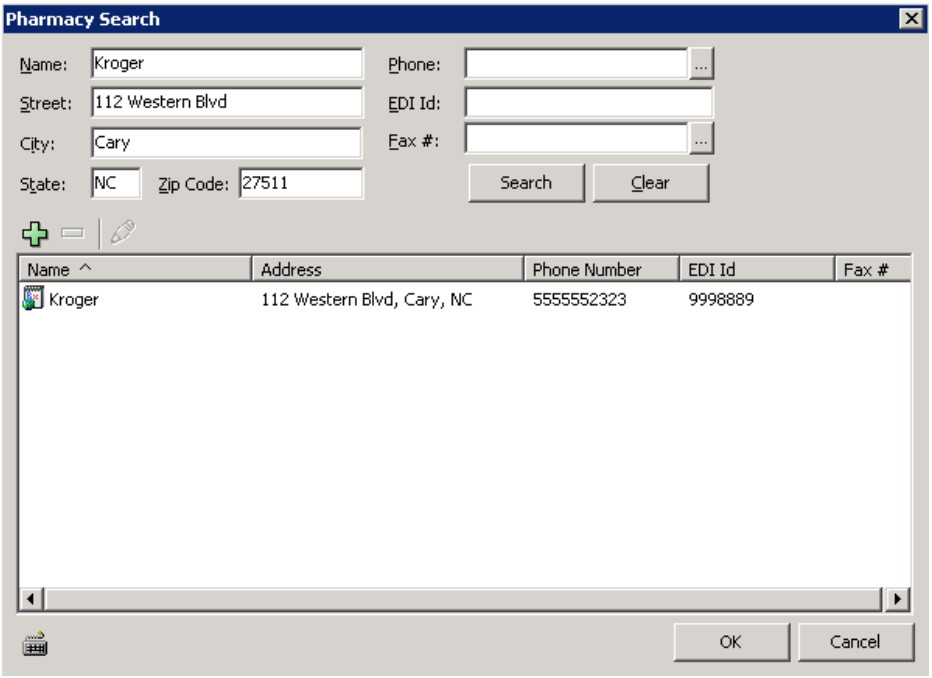
3. Select the correct patient and click **OK** to display the name in the *Patient* field in the eRefill Request view.

4. Approve the eRefill request (see Approving matched eRefill requests on page 60).

NOTE: When the missing information is reconciled, and the medication is selected (at the bottom of the eRefill Requests screen, the icon in the upper pane changes to . If it does not, that means that the pharmacy also needs to be matched (see To match pharmacies on page 59).

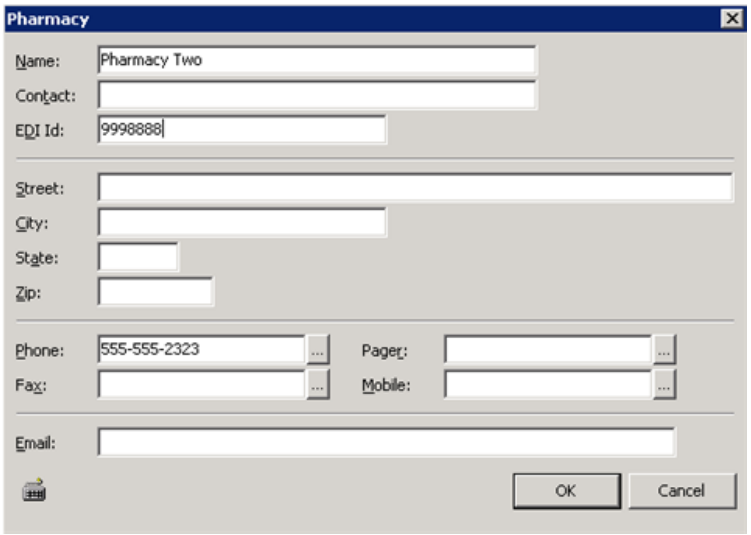
To match pharmacies

1. With an eRefill request selected, click the **Pharmacy** search button ( ).



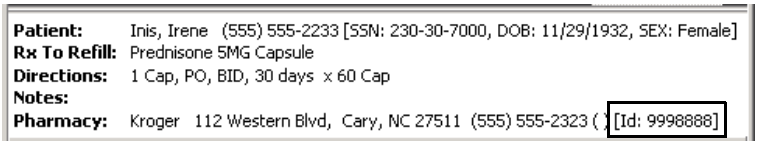
NOTE: If the correct pharmacy name displays, select it and click **OK**. Otherwise, follow the steps below.

2. Enter a few characters of the pharmacy's name and click **Search**.
3. If no matching pharmacy displays, click to display Pharmacy.



- Enter pharmacy information as needed.

NOTE: At *EDI Id*, copy and paste the pharmacy NCPDP ID found in the Electronic Refill Reconciler *Pharmacy* information.


Patient: Inis, Irene (555) 555-2233 [SSN: 230-30-7000, DOB: 11/29/1932, SEX: Female]
Rx To Refill: Prednisone 5MG Capsule
Directions: 1 Cap, PO, BID, 30 days x 60 Cap
Notes:
Pharmacy: Kroger 112 Western Blvd, Cary, NC 27511 (555) 555-2323 ( ) [Id: 9998888]

- Click **OK** to display the pharmacy information in the *Pharmacy* field.

4. Approve the eRefill request (see Approving matched eRefill requests on page 60).

NOTE: When the missing information is reconciled, and the medication is selected (at the bottom of the eRefill Requests screen, the icon in the upper pane changes to . If it does not, that means that the patient also needs to be matched (see To match patients on page 58).

To match maintenance medications not previously recorded

1. With an eRefill request is selected, on the secondary toolbar, click (Face Sheet) and in the *Medications* pane.
   - Click to display *All* medications, including inactive and discontinued.
   - If the eRefill request does not match any medication in the patient's Medication list, "order" it in Assessment/Plan, enter a Historical Entry comment and assign a non-billable visit code (see Ordering and viewing medications from assessment/plan on page 303) ***or*** reject the request (see Rejecting eRefill requests on page 62).
   - Click **Close** to return to eRefill Requests.
2. To add a maintenance medication to the patient chart, click (Quick Assessment/Plan), add the medication (see Assessment/Plan on page 291), and sign off on the chart (see Signing off charts on page 364).
3. Return to eRefill Requests and select the newly added medication.
4. Approve the eRefill request (see Approving matched eRefill requests on page 60).

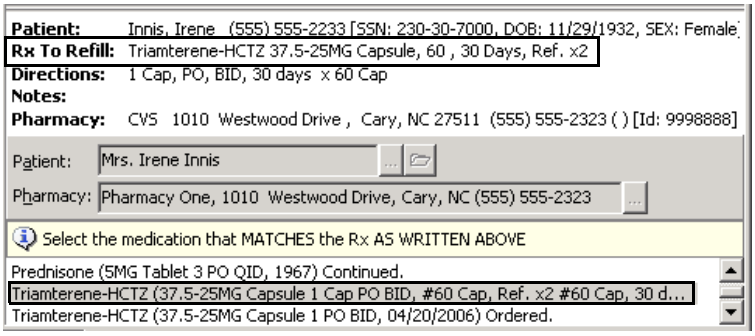
Approving matched eRefill requests

IMPORTANT! The eRefill response message returned by the practice to the pharmacy always contains the **original** prescription sent by the pharmacy. An approval message approves the **original** prescription sent, a rejected message rejects the original prescription sent. Caregivers must manually match the medication so documentation in HealthMatics EMR matches the pharmacy information.

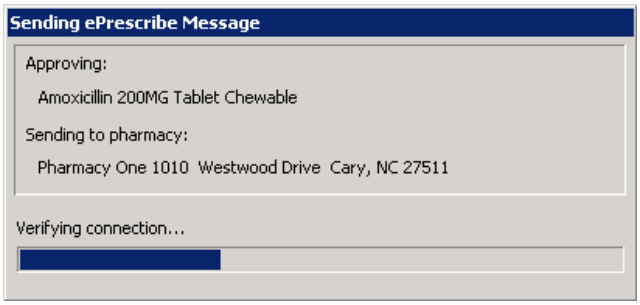
NOTE: eRefill requests can only be approved by caregivers who have privileges for approving electronic prescriptions and also have access to the patient's chart.

1. Access **eRefill Requests** (see Viewing eRefill requests on page 56).
2. Select a matched ( ) eRefill request.

3. In the reconciler pane at the bottom of the screen, select the medication from the HealthMatics EMR database that exactly matches **Rx To Refill**.


Patient: Innis, Irene (555) 555-2233 [SSN: 230-30-7000, DOB: 11/29/1932, SEX: Female]
Rx To Refill: Triamterene-HCTZ 37.5-25MG Capsule, 60 , 30 Days, Ref. x2
Directions: 1 Cap, PO, BID, 30 days x 60 Cap
Notes:
Pharmacy: CVS 1010 Westwood Drive , Cary, NC 27511 (555) 555-2323 ( ) [Id: 9998888]
Patient: Mrs. Irene Innis
Pharmacy: Pharmacy One, 1010 Westwood Drive, Cary, NC (555) 555-2323
Select the medication that MATCHES the Rx AS WRITTEN ABOVE
Prednisone (5MG Tablet 3 PO QID, 1967) Continued.
Triamterene-HCTZ (37.5-25MG Capsule 1 Cap PO BID, #60 Cap, Ref. x2 #60 Cap, 30 d...
Triamterene-HCTZ (37.5-25MG Capsule 1 PO BID, 04/20/2006) Ordered.

4. On the eRefill Requests secondary toolbar, click **Approve**.
   A screen displays showing that the system is sending an ePrescribe message.



NOTES

***** The Sending ePrescribe Message displays the progress of the connection to the ePrescribe Gateway. The action being taken and the medication being approved displays in the message to provide feedback so that you will know exactly what is being sent to the pharmacy.

* The name of the caregiver who approves the request is added to the saved eRefill Request on the patient face sheet and also is sent electronically to the pharmacy.

* You can not prescribe controlled substances electronically, which includes faxing and eRefills. The **Approve** button is disabled on the eRefill Request screen if a controlled substance is selected.

* You must enter a password to approve or reject all eRefill requests, as well as new requests.

CAUTION!

- Pressing **Approve** immediately sends a *Refill Approved* eRefill Response message back to the pharmacy via the SureScripts and ePrescribe Gateway. This eRefill Response message contains the original prescription sent by the pharmacy and not the medication selected from the patient medication list. If the wrong medication is selected from the medication list, the pharmacy still receives the medication originally sent in the eRefill Request, but whatever medication is selected from the patient medication list is the medication documented and automatically saved to the patient chart.

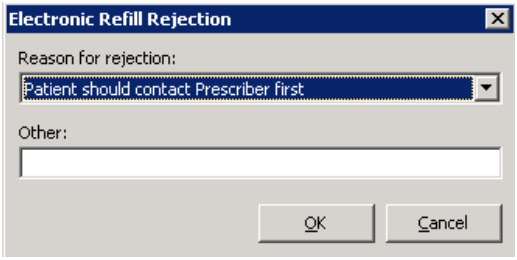
If the approval does not transmit properly, send a fax to the pharmacy in the Fax dialog box that displays (**IF** faxing is enabled at your practice**)**.

- When **faxing** the medication approval to the pharmacy, the selected medication in the patient medication list is faxed to the pharmacy and **not the original** prescription sent by the pharmacy. If the fax does not go through, a failure message contains the name of the pharmacy, along with the medication name, patient name, and fax number.

Rejecting eRefill requests

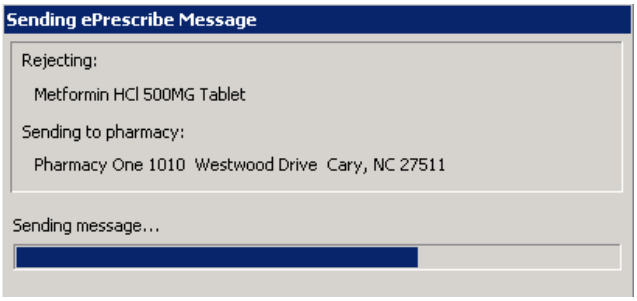
Any authorized caregiver can reject an eRefill request. No reconciliation or matching is required to do so. Rejecting an eRefill Request prompts the caregiver for a rejection reason and password and immediately sends an eRefill Response *Refill Denied* message back to the pharmacy.

1. In the left pane of the HealthMatics EMR desktop or from the **Office** menu option, select **eRefill Requests**.
2. Select an eRefill request, click **Reject > Reject**.
3. Enter a password and click **OK**.



   - Click the **Reason for rejection** down-arrow and select a reason for the rejection ***or***
   - At *Other*, enter a custom reason (up to 70 characters in length).

4. Click **OK.**



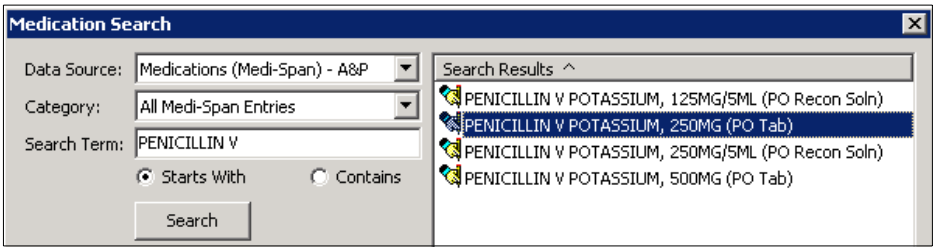
The Sending ePrescribe Message box displays briefly.

NOTE: A *Refill Denied* refill response message goes immediately to the pharmacy.

Rejecting eRefills and sending new prescriptions

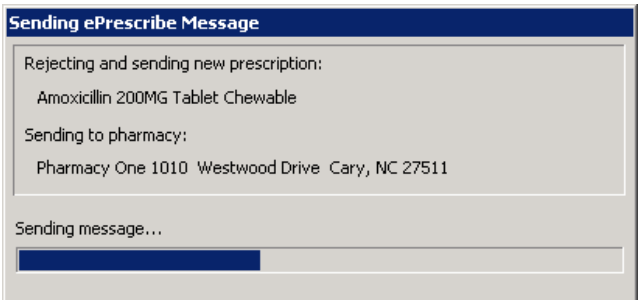
NOTE: See also Rejecting eRefill requests on page 62.

1. In the left pane of the HealthMatics EMR desktop ***or*** from the **Office** menu option, select **eRefill Requests**.
2. Select a pending eRefill request and click **Reject > Reject, Send New Prescription**.
3. Enter your password and click **OK** to display Medication Search.



4. Enter a *Search Term*, click *Starts With* or *Contains*, and click **Search**.
5. In *Search Results*, select the new medication and click **OK** to display the Medication dialog box.
6. Enter medication details as needed and click **OK** (see also Approving or rejecting refill requests on page 48).

Sending ePrescribe Message displays the transmission progress of the new prescription.


Sending ePrescribe Message
Rejecting and sending new prescription:
Amoxicillin 200MG Tablet Chewable
Sending to pharmacy:
Pharmacy One 1010 Westwood Drive Cary, NC 27511
Sending message...

Sending new prescriptions electronically

NOTE: To prescribe medications electronically, your practice must have purchased and enabled (in **Administration Module > System Options**) ePrescribe, and you be set up with a SureScripts Provider (SPI ID) and password.

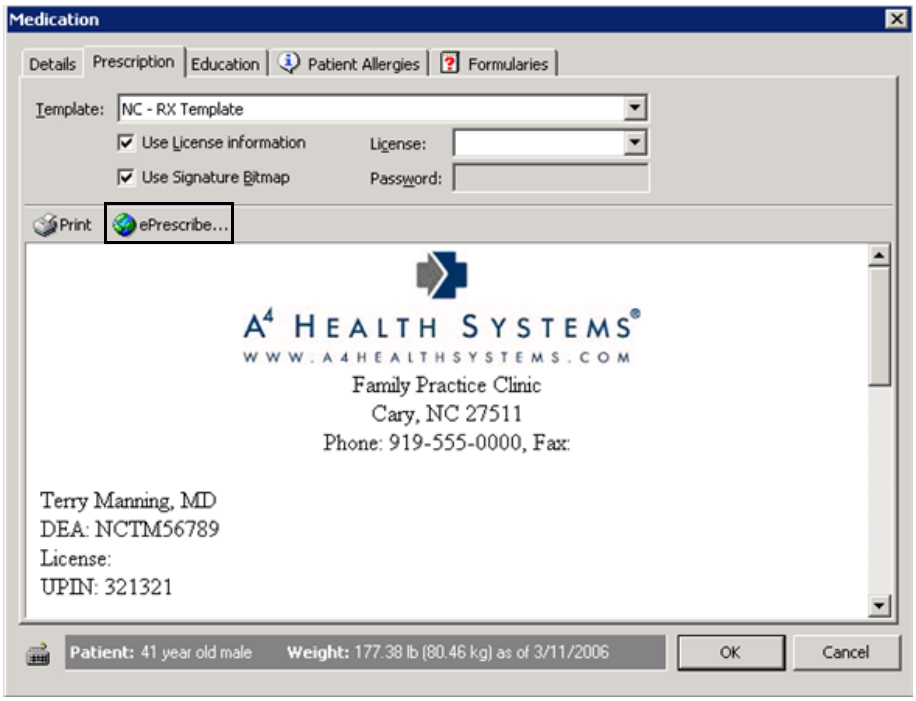
Prescriptions can be transmitted to selected pharmacies via the secure ePrescribe Gateway and on to the SureScripts network for message delivery.

1. With a patient's chart open, from the left pane ***or*** the toolbar, click **A/P** (Assessment/Plan).
2. Verify that the medication has not previously been prescribed by clicking the **Patient Medications** tab and viewing the medications list.
3. Then click the **Search** tab to order a new prescription.

- Click the **Data Source** down-arrow and select **Medications (Medi-Span)**.
- At *Search Term*, type a few characters for your search, select either **Starts With** or **Contains,** and click **Search**.
- In *Search Results*, double-click the medication you want to prescribe.

4. In the Medication dialog that opens, enter details as needed and click the **Prescription** tab.

   - Click the **Template** down-arrow and select a template for the prescription.



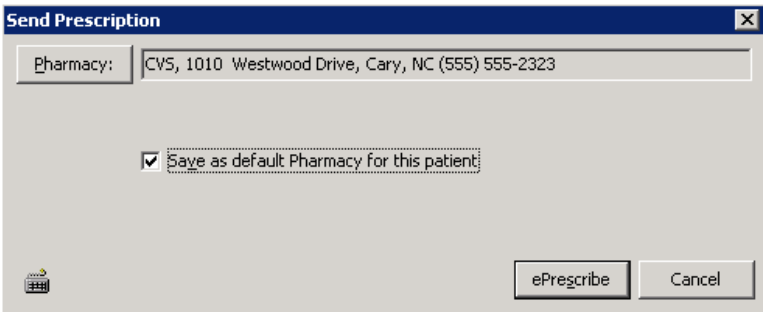
NOTES
* If your system is not set up to send prescriptions electronically, the **ePrescribe** button does not display.

* If your system is set up to fax but **not** ePrescribe ***or*** if the caregiver is not able to use ePrescribe, a **Fax** button displays instead.

* If there is a problem sending the medication electronically, you can fax it instead.

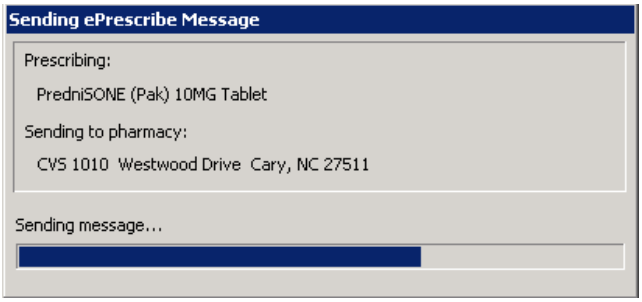
- Select or enter other information on the screen as needed and click (ePrescribe).

5. Enter your password and click **OK** to display Send Prescription.



NOTE: If the select pharmacy is not configured to accept electronic prescriptions, a warning displays in the Send Prescription dialog box.

- If *Pharmacy* is blank or incorrect, click **Pharmacy** to find the correct one in Pharmacy Search and click **OK** to return to Send Prescription.
- Select **Save as default Pharmacy** for this patient if appropriate.
- Click **ePrescribe** to display a progress dialog.



NOTES

- If the default pharmacy for the patient has a valid Pharmacy ID, the ePrescribe message is sent immediately. If there is a problem during transmission, a warning displays to allow the caregiver to change the pharmacy if possible. If a message states: *The selected pharmacy has not been configured for e-Prescriptions*, you can fax the prescription if you are set up to do so, or try updating your pharmacy SureScripts IDs from the **A4 Client Website**. From the website, select **HealthMatics EMR > Electronic Prescribing**. The information on the website is updated at least once a month.
- The **ePrescribe** button is enabled only if the provider is enrolled and the selected pharmacy has a Pharmacy ID (NCPDP ID). If it does not, an icon and label explain that the pharmacy is not set up correctly.
- SPI IDs are required to initiate new prescriptions but not to respond to a eRefill requests.

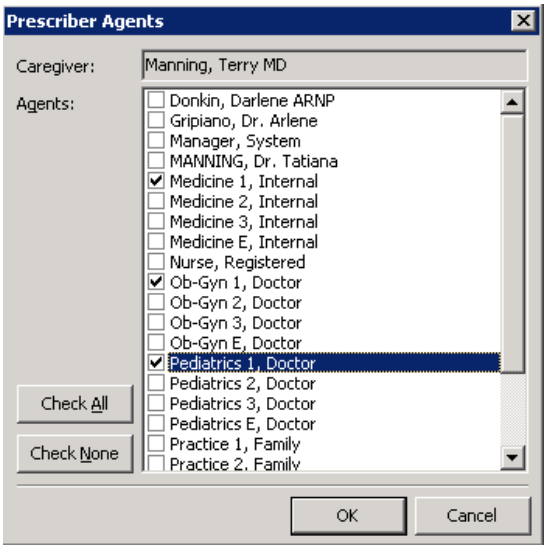
Setting up electronic prescribing in administration

To set up and manage the ability to use electronic prescribing, in the HealthMatics **Administration Module**, you can do the following:

- To assign prescribing agents for caregivers on page 66
- To set refill request password prompts on page 66
- To run ePrescribe synchronization immediately on page 67
- Setting up electronic prescription pharmacies on page 67

To assign prescribing agents for caregivers

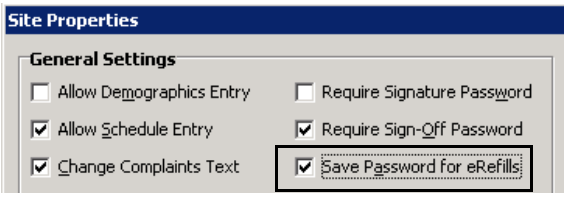
1. From the menu bar, select **Launch > Administration Module > Caregivers**.
2. Select a caregiver and click **> Prescriber Agents**.



3. Click to select the boxes in front of all caregivers authorized to respond to eRefill Requests sent to your inbox, and click **OK**.

To set refill request password prompts

1. From the menu bar, select **Launch > Administration Module > Site Settings**.
2. On the secondary toolbar, click **> Edit**.
3. Under *General Settings*, do one of the following:



- Select **Save Password for eRefills** to allow caregivers to enter their password **one time** and then approve/disapprove multiple eRefills without leaving the

screen. Upon leaving the screen, the password is cleared and must be entered again the next time the screen is accessed ***or***

- Deselect the box to require caregivers to enter a password for **each** eRefill approval/rejection.

4. Click **OK** to save the setting.

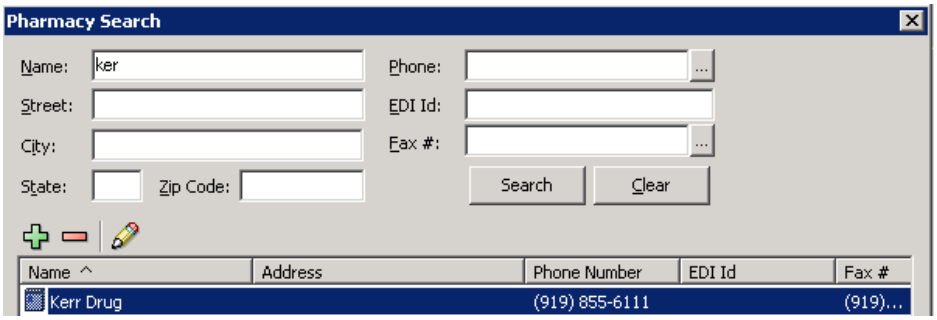
To run ePrescribe synchronization immediately

1. From the menu bar, select **Launch > Administration Module > Scheduled Tasks**.
2. Select **ePrescribe Synchronization** from the list.
3. On the secondary toolbar, click **Run Now** and then **OK**.

Setting up electronic prescription pharmacies

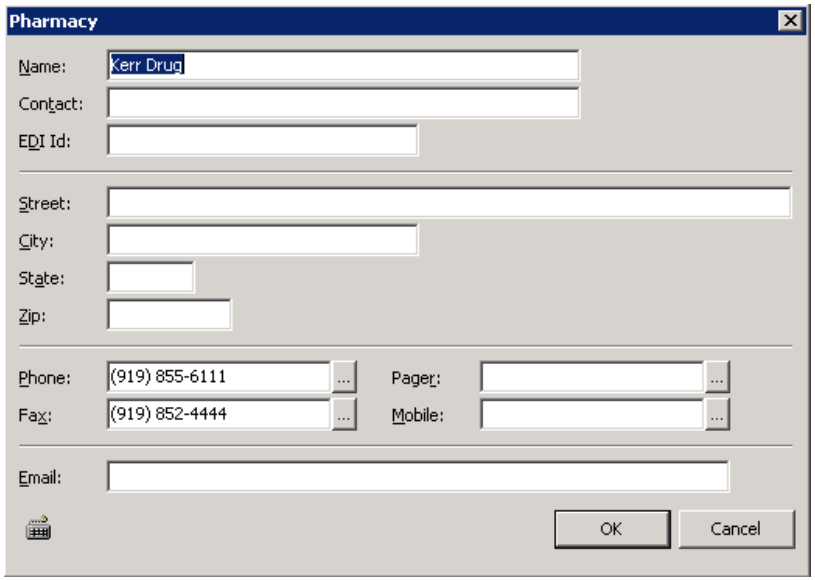
NOTE: You can send electronic prescriptions only to pharmacies with a unique NCPDP ID set up.

1. From the HealthMatics EMR menu bar, select **Tools > Edit Pharmacies**.



At *Name*, enter a few characters for the pharmacy name and click **Search**.

2. Select a pharmacy and press **F2** ***or*** click (Edit Selected Item).



- At *EDI Id*, enter a unique NCPDPD ID for this pharmacy and click **OK**.
- In Pharmacy Search, click **Close** at the bottom right corner to exit.

Using biometric authentication with electronic prescriptions

As an option to practices that require biometric authentication, HealthMatics ePrescribe supports the use of fingerprint verification when sending an electronic message. Biometric authentication is implemented by third-party software that is integrated into HealthMatics EMR. HealthMatics ePrescribe can be set up to require the use of biometric authentication by setting a system option requirement in HealthMatics Administration.

IF biometric authentication **is required** the caregiver is always prompted for a fingerprint immediately before the new prescription or refill response is transmitted. If the third party software is not installed correctly on the client machine, an error message displays and the message will not transmit.

IF biometric authentication is **not required**, but third party software is installed on the client machine, the caregiver is prompted for their fingerprint when sending a new prescription or a refill response.

IF biometric authentication is **not required and** third party software is not installed on the client machine, no biometric authentication occurs.

To use biometric authentication the practice must do the following

- Install SAFSolution client software.
- Add caregiver login names to domain, and enroll the users with the SAFSolution client software.
- Add biometric authentication system options in the **Administration Module**.

To add biometric authentication system options

Biometric authentication functionality uses three system options. To set them, go to **Launch > Administration Module > System Options**, and follow the steps below:

1. Click the **Display Section** down-arrow and select **Biometric Authentication**.
2. To enable biometric authentication, double-click *Key* word, **Disabled**, and enter a *Value* of **1**. Click **OK**.

   NOTE: To disable biometric authentication, change the *Value* back to **0**.
3. Double-click *Key* word, **Domain**, at *Value*, and enter the name of your Windows domain. Click **OK**.
4. Double-click *Key* word, **Required** and either enter a *Value* of **1** to require the use of biometric authentication for electronic prescriptions ***or*** leave it at **0** to make it optional. Click **OK**.

To use biometric authentication with electronic prescriptions

1. Approve an eRefill request by following the steps in Approving matched eRefill requests on page 60,
2. On the screen that requires a password, leave the *Password* field blank.
    - **IF** the password is blank, the biometric authentication hardware and software has been installed, and the system administrator has enabled the Biometric Authentication system options, you receive a prompt for a fingerprint.
    - **IF** any of the above conditions are not met, you receive the message, “Enter a valid password.”
    - **IF** a password is entered and the system has been set to require biometric authentication, the system ignores the password and prompts for a fingerprint.
3. When sending a prescription electronically, if you have not entered a password on the screen, the following happens:
    - You are prompted for the password via a pop-up authentication dialog.
    - If you leave the password in this dialog blank, you are asked for your fingerprint.

- If biometric authentication is **required**, the dialog does not display and you are prompted for your fingerprint.

Documents

Documents are system-generated messages that accompany documents sent to you for review and approval, including scanned documents and internal and external transcription.

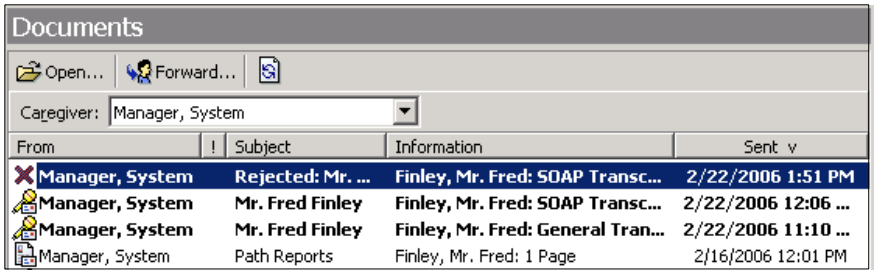
For general instructions for using HealthMatics EMR windows, see Windows, Panes, and Other Tools on page 8.

After a user scans or transcribes dictation and submits it (regardless of whether it is new or changed), the system sends a message to the appropriate caregiver that it is awaiting review and approval before being filed in the patient's chart.

Viewing the list of documents

The *Documents* view on your desktop lists documents that have been sent to you for review and/or approval.

1. From the status bar ***or*** the left pane of the HealthMatics EMR desktop ***or*** the **Office** menu bar option, click . (Documents).



NOTE: The following icons precede the various document types:

Icon	Document Type
	External transcription - Soap or General
	Internal transcription - Note from *Voice* tab
	Scanned document
	Rejected document

2. Open a document for viewing by using any of the following methods:
   - On your keyboard, press **Ctrl+O** ***or***
   - Double-click the document ***or***
   - On the toolbar, click Open ***or***
   - Right-click and select **Open**.

NOTE: Secondary toolbar icons:

Icon	Name	Action
	Open (**Ctrl+O**)	Open the selected document for review and approval (see To approve or reject scanned documents on page 74).
	Forward (**Ctrl+F**)	Forward the selected document. Enter comments in Edit Transcription and forward it back to the transcriber or scanner. See Documents on page 70.
	Refresh (**F5**)	Display new documents sent to you recently if you cannot wait until the screen refreshes itself automatically. To set the Refresh default time, see To set desktop defaults on page 109.

See also Viewing other caregivers' inboxes on page 28.

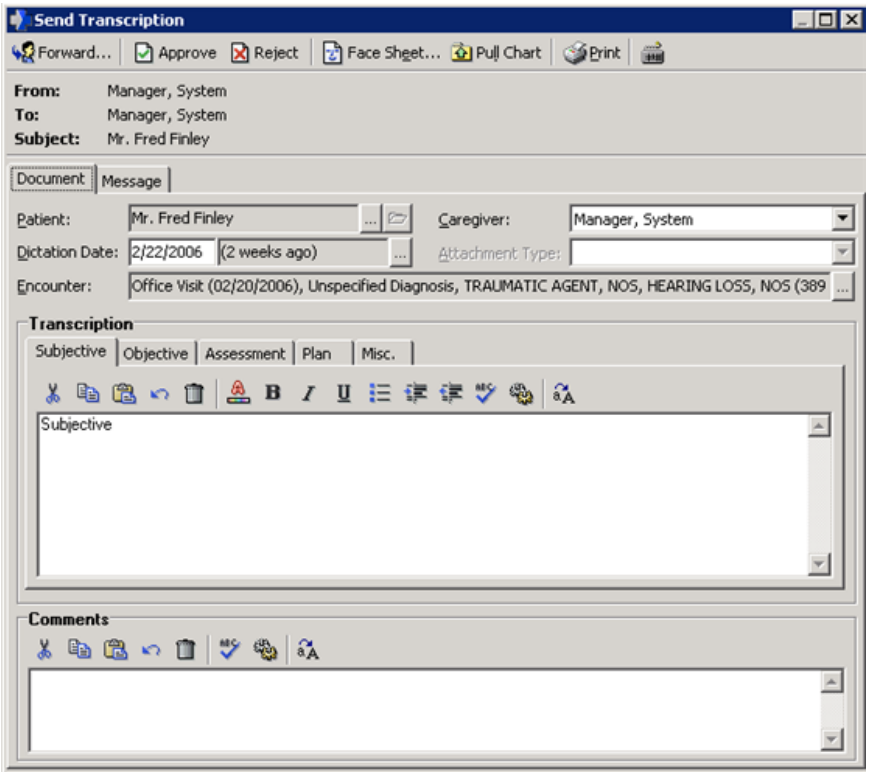
Approving or rejecting documents

NOTE: For information about transcribing external dictation, refer to the ***Input Manager*** manual.

To approve or reject external transcriptions

External transcription can be general or in the standard SOAP format.

1. In the Documents view, open an external transcription document (see Viewing the list of documents on page 70).



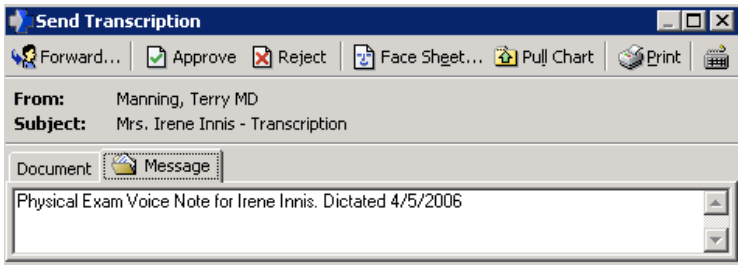
2. Read the text (if any) on the **Message** tab.
3. Click the **Document** tab and check the identifying information in the top half of the Send Transcription screen, revising if needed.
   - Click the **Patient** search button (...) to match the dictation with a different patient ***or***, if a patient chart is currently pulled on the desktop, click (Use Current Chart).
   - Click the **Attachment Type** down-arrow to correct the type of transcription.
   - Click the **Dictation Date** search button (...) to change the date.
4. Review the transcription:
   - **General transcription** is saved to the patient chart as an attachment. Therefore, it has an *Attachment Type (*such as *Consultation Report* or *Historical Summary*) assigned to it. General transcription text displays in the *Transcription* text box.
   - **SOAP** transcription is **not** associated with an *Attachment Type* and will appear as part of the *H&P Report* for the selected encounter. Read the text by clicking on each of the tabs (*Subjective, Objective, Assessment, Plan*, and *Misc*.).
5. Click toolbar icons to do any of the following:

Icon	Name	Action
	Forward	Forward the document to another caregiver. If a rejected document is forwarded, the status changes back to *Submitted*.
	Approve	Approve the document (after checking/adjusting the index information and adding a comment, if desired) save it to the patient's chart.
	Reject	Reject the document (after entering a reason for the rejection) and return it (with a message) to the indexing caregiver.
	Face Sheet	View the patient's face sheet.
	Pull Chart	Pull the patient's chart and leave the document without taking any action on it.
	Print (**Ctrl+P**)	Print the document.
	Keypad	Access the keypad.

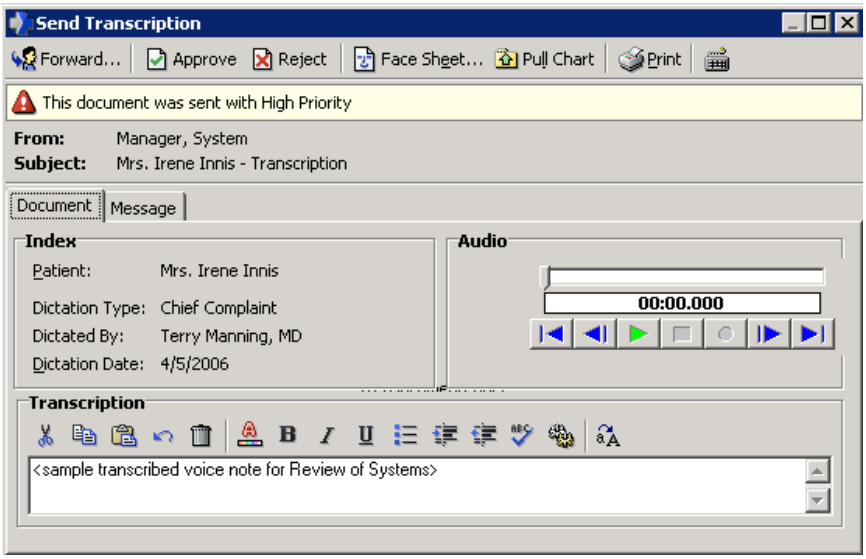
To approve or reject internal (voice note) transcriptions

NOTE: For instructions for recording voice notes in HealthMatics EMR, see Entering voice messages in notes on page 349 and Internal Transcription on page 135.

1. In the *Documents* view, open an internal transcription ( ) document (see Viewing the list of documents on page 70) and read the message (if any) on the *Message* tab.



2. Click the **Document** tab.



3. Review the *Transcription* text, clicking **Audio** buttons, if needed, to review your dictation (see Internal Transcription on page 135).

4. Click the toolbar icons to do any of the following:

Icon	Name	Action
	Forward	Open Send Transcription to forward the document to another caregiver. You can enter an additional text message before clicking **Send**.
	Approve	Approve the transcription. The transcription is saved in the appropriate section of the H&P Report. **NOTE:** You must have the appropriate Function Access.
	Reject	Reject the transcription and return it to the transcriptionist. **NOTE:** You must have the appropriate Function Access.

Icon	Name	Action
	Face Sheet	Open the patient's face sheet. Click the **X** in the right corner to close the face sheet and return to Send Transcription.
	Pull Chart	Close Send Transcription and pull the patient's chart.
	Print	Open Print Preview
	Keypad	Open the keypad to enter text.

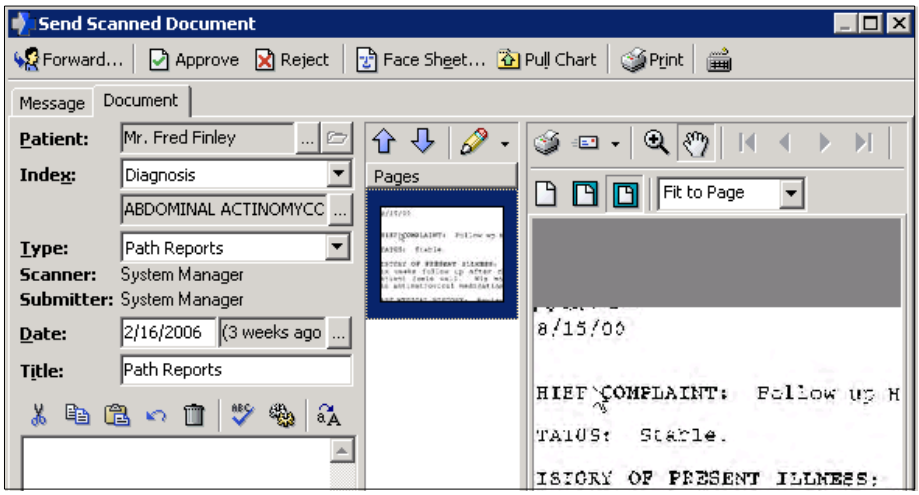
To approve or reject scanned documents

NOTE: For instructions for scanning documents, refer to the ***Input Manager*** manual.

You can scan paper documents into the HealthMatics EMR database, associate them with patient charts, and then send them to the caregiver for review or save directly to the chart. Scanned documents awaiting review are sent to caregiver inboxes as *Documents*.

Scanned documents are distinguished from other documents by the icon.

1. In the Documents view, open a scanned document (see Viewing the list of documents on page 70).
2. If the **Message** tab has an icon on it, click the tab to read the sender's message, and then click the **Document** tab.



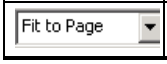
3. Verify that the patient and indexing information on the left is correct, revising if needed.
4. In the middle pane, click thumbnails to display the pages of the document in the preview pane on the right.

NOTES

*IF an image needs to be rotated, click and select a rotation option:

* **IF** the pages are in the wrong order, click a thumbnail and then click or to move the page up or down, respectively.

5. Use the icons over the preview pane on the right to do the following:

Icon	Name	Action
	Print Document (**Ctrl+P**)	Displays a Print Document dialog.
	Send Message	• Send Patient Message to another caregiver about the document. • Send Reminder to the chart.
	Zoom Cursor	Click the icon and then click the image to magnify it.
	Move Cursor	Click the icon and then click and drag the image to move it up/down and left/right.
	Navigate to First Page (**Ctrl+Home**)	Return to the first page of a multi-page document.
	Navigate to Previous Page	Move to the previous page of a multi-page document.
	Navigate to Next Page	Move to the next page of a multi-page document.
	Navigate to Last Page (**Ctrl+End**)	Move to the last page of a multi-page document.
	Zoom to 100%	Enlarge the document to 100%.
	Zoom to Fit Page Width	Enlarge the document to fit the page width.
	Zoom to Fit Whole Page	Enlarge the document to fit the whole page.
	Select zoom %	Click the down-arrow to select the size.

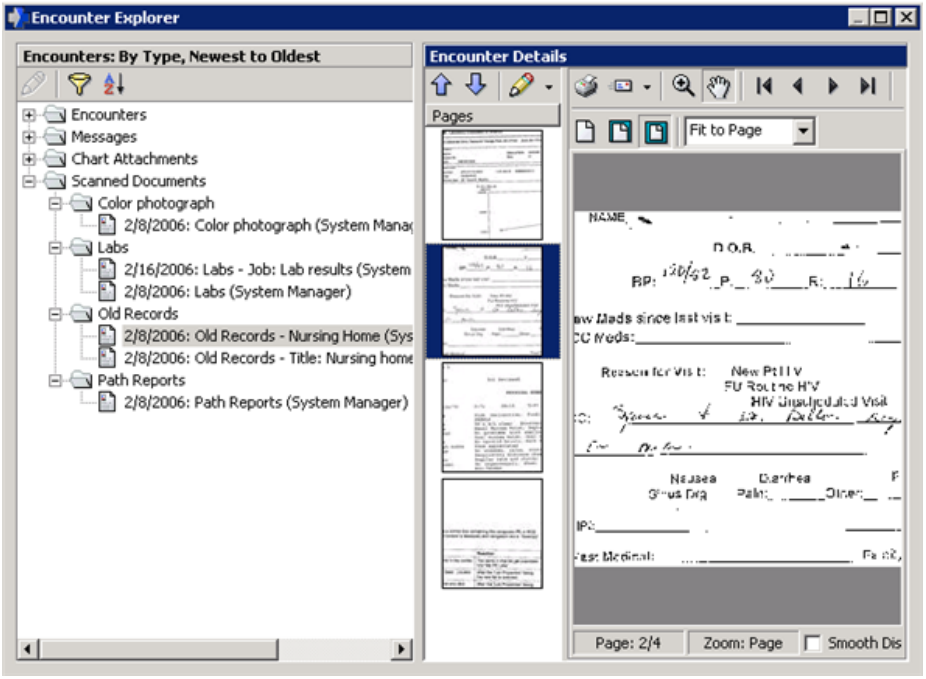
NOTE: You can view the patient's Face Sheet in a dialog by clicking on the toolbar, and then closing the dialog to return to Send Scanned Document ***or*** you can close the Send Scanned Document screen and pull a patient's chart by clicking (Pull a Chart).

6. After verifying the index information on the left and the quality of the scanned document on the right, click toolbar icons to do any of the following:

Icon	Name	Action
	Print	Print the document
	Approve	Approve the document and link it to the patient's chart as an attachment.
	Reject	Return the document to the scanner for corrections. **NOTE:** When rejecting a scanned document, the message text box reopens. Enter a reason for the rejection.

Viewing scanned documents from face sheets

1. Open a patient's face sheet and, in the *Encounters* pane, click (View Encounters).
2. Click to filter the encounters *By Type*.
3. Expand the Scanned Documents folders as needed to locate the document you want to view and click to select it.



4. In the middle pane, click thumbnails to view each page in the preview pane on the right.

NOTE: For additional instructions for using this screen, see To approve or reject scanned documents on page 74.

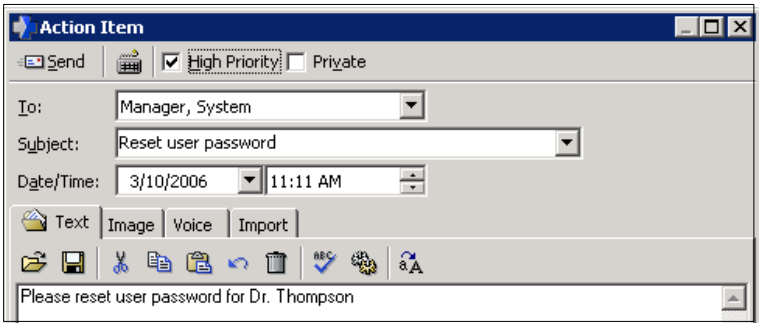
Action Items

Action Items are user-created messages about things to do or personal reminders. You can send action items to yourself or to other caregivers.

For general instructions for using HealthMatics EMR windows, see Windows, Panes, and Other Tools on page 8.

Creating action items

1. From the left pane of the HealthMatics EMR desktop, select **Action Items *or***, from the toolbar, select **> Send Action Item.**



   Your login name and the current date and time display as the default.

2. Select checkboxes as desired:
   - **High priority** - Select to display the message in red in the recipient's inbox.
   - **Private** - Select to hide the item from other users who may have access to view the recipient's Inbox.
3. To select a different recipient, click the **To** down-arrow.
4. At *Subject*, enter a subject ***or*** click the down-arrow to select one.

   NOTE: To add message subjects to drop-down lists, refer to *Message Subjects* in the ***Administration Module*** manual).
5. To change the date, enter a new date ***or*** click the down-arrow to select one (see Entering dates on page 10).

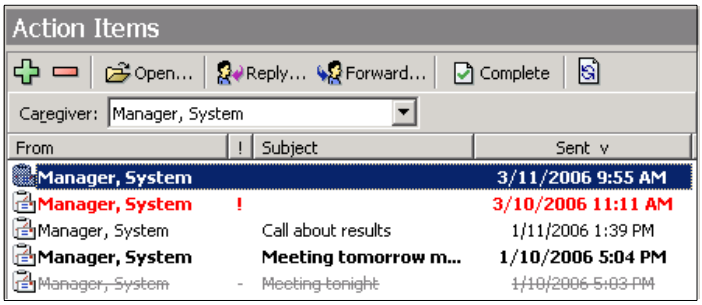
   NOTE: If you specify a future date, the action item does not display in the recipient's inbox until the date selected
6. To change the time, enter a new time ***or*** click the scroll arrows.

   NOTE: If you specify a future time, the action item does not display in the recipient's inbox until the time selected.
7. Enter information on any of the four tabs (see Entering data on tabs on page 32) and click **Send**.

The message appears in your *Outbox* immediately and the recipient's *Inbox* at the date and time selected.

Viewing action Items

1. From the status bar or left pane of the HealthMatics EMR desktop, click (Action Items).



NOTES

***** The number next to *Action Items* -- 3 on the status bar, and in the left pane of your desktop in your *Inbox* and *Office Manager* -- is the number of action items not yet marked *Complete*.

* If the urgent message indicator is turned on, the number that flashes in red indicates the number of items designated *High Priority* (see Urgent message indicator on page 6).

* To view another caregivers' action items for whom you've been granted access, click the **Caregiver** down-arrow to select the caregiver's name. Their *Action Items* display. (Set grants in **Administration Module > Caregivers >** select caregiver **> > Grants.**)

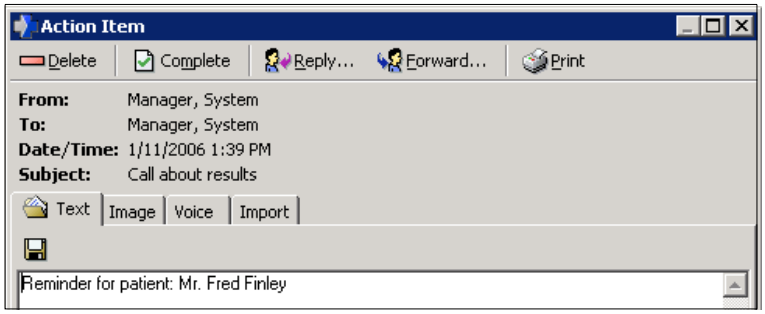
2. Select an action item and click toolbar icons ***or*** right-click for a drop-down menu to do any of the following:

Icon	Name	Action
	New (**Ins**)	Create a new action item. See Action Items on page 77.
	Delete (**Del**)	Delete the selected message.
	Open (**Ctrl+O**) **or** double-click	Once opened, click any of the tabs with icons on them (*Text, Image, Voice*, or *Import*) to view the message.
	Reply (**Ctrl+R**)	Reply to the sender. (or any other caregiver).
	Forward (**Ctrl+F**)	Forward the action item to another caregiver.
	Complete (**Ctrl+C**)	Mark the selected item *Complete*. **NOTE:** The item displays in your inbox grayed out with a line through.
	Refresh (**F5**)	Display new action items sent to you recently, if you cannot wait until the screen refreshes itself automatically. **NOTE:** To set the Refresh default time, see To set desktop defaults on page 109.

See also Viewing other caregivers' inboxes on page 28.

Responding to action items

1. From the status bar or left pane of the HealthMatics EMR desktop or *Office Manager*, click (Action Items).
2. Open an item (see Viewing action Items on page 78).



3. Click the toolbar icons to do any of the following:

Icon	Name	Action
	Delete	Delete the selected message in the inbox. **NOTE:** A system-generated action Item resulting from a patient reminder remains as a permanent entry in the patient's chart after it is deleted from your inbox (see also Reminders on page 211).
	Complete	Mark the selected action item *Complete*, but leave it in the inbox grayed out with a line through it.
	Reply to Sender	Send a message back to the person who sent the action item.
	Forward Message	Forward the action item to another caregiver.
	Print	Print the action item message.

Received Charts

Received Charts are system-generated messages accompanying charts that other caregivers send to you by clicking **Send Chart**. Charts may be for scheduled patients waiting in exam rooms, or for charts that require your review, such as exams performed by Physician Assistants or other caregivers.

For general instructions for using HealthMatics EMR windows, see Windows, Panes, and Other Tools on page 8.

1. On the status bar or left pane of the HealthMatics EMR desktop or Office Manager, click (Received Charts).

Select a message and click toolbar icons ***or*** right-click for a drop-down menu to do any of the following:

Icon	Name	Action
	Delete (**Del**)	Delete the selected chart message.
	Open (**Ctrl+O**) **or** double-click	Once opened, click any of the tabs with icons on them (*Text, Image, Voice*, or *Import*) to view the chart message.
	Reply (**Ctrl+R**)	Reply to the chart message. (or any other caregiver).
	Forward (**Ctrl+F**)	Forward the chart to another caregiver.
	Refresh (**F5**)	Display new action items sent to you recently, if you cannot wait until the screen refreshes itself automatically. **NOTE:** To set the Refresh default time, see To set desktop defaults on page 109.

2. Open the chart message and click toolbar icons to do any of the following.

Icon	Name	Action
	Delete (**Del**)	Delete the selected chart message.
	Pull Chart	Close the *Received Charts* view and open the patient's chart for review. Click **Yes** to delete the chart message from your inbox once the chart is pulled.
	View H&P	View the patient's current H&P Report (in a separate dialog). Close the H&P Report dialog to return to the Chart Message.

Icon	Name	Action
	Reply to Sender	Displays the Chart Message dialog. Enter a new message back to the original sender and click **Send** (or **Ctrl+Enter**) to return the message and chart. Click **Yes** to delete the original message from your inbox. The message and chart are removed from your inbox and returned to the original caregiver's inbox.
	Forward Message	Displays the Chart Message dialog. Fill in the *To:* and *Subject:* fields as needed, and click **Send** (or **Ctrl+Enter**) to forward the message and chart to a caregiver other than the one who originally sent it to you. Click **Yes** to delete the original message from your Inbox.
	Print	Print the message.

See also Viewing other caregivers' inboxes on page 28.

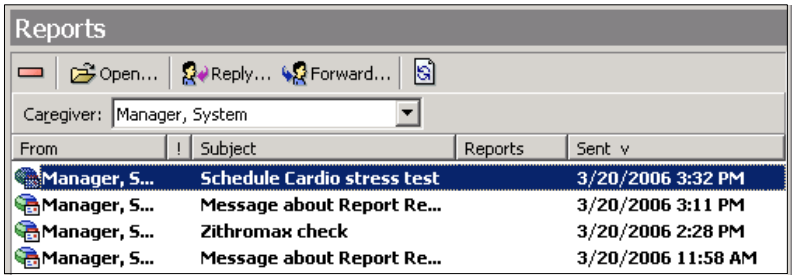
Reports

Reports are user-generated messages accompanying report results that other caregivers send to you for action.

For general instructions for using HealthMatics EMR windows, see Windows, Panes, and Other Tools on page 8.

Processing report messages

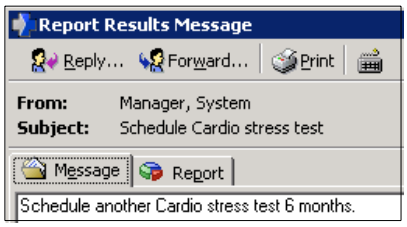
1. On the status bar or left pane of the HealthMatics EMR desktop or *Office Manager*, click (Reports).



You can select a message and click toolbar icons ***or*** right-click for a drop-down menu to do any of the following:

Icon	Name	Action
	Delete (**Del**)	Delete the selected chart message.
	Open (**Ctrl+O**) **or** double-click	Once opened, click either tab • Message - To view requested action • Report - To view the results of the report
	Reply (**Ctrl+R**)	Reply to the chart message. (or any other caregiver).
	Forward (**Ctrl+F**)	Forward the chart to another caregiver.
	Refresh (**F5**)	Display new action items sent to you recently, if you cannot wait until the screen refreshes itself automatically. **NOTE:** To set the Refresh default time, see To set desktop defaults on page 109.

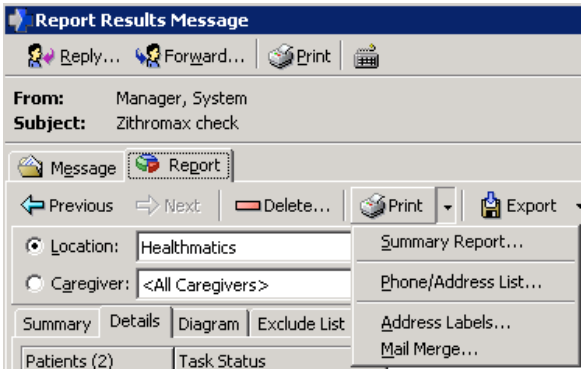
2. Open an item, and, on the *Message* tab, read the instructions for action needed.



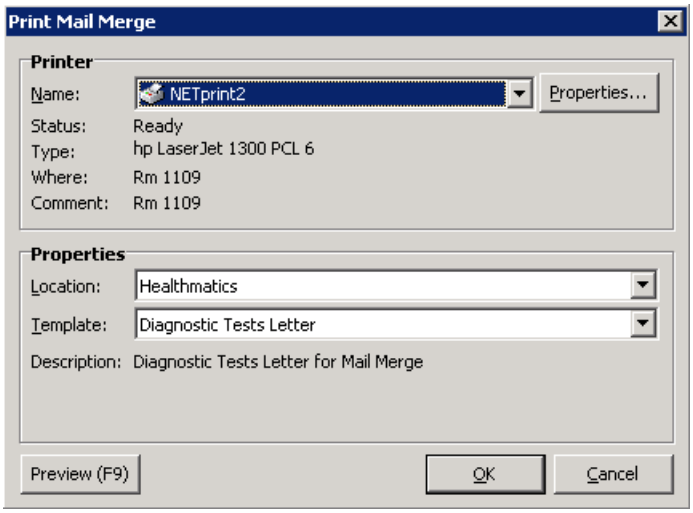
3. Click the **Report** tab to display report results on the following tabs:
   - **Summary** - Graph and *Totals* of the report results
   - **Details** - List of patients included in the report
   - **Diagram** - Diagram of report parameters
   - **Exclude list** -List of patients excluded from requested action

Performing mail merges

1. From the inbox, select **Reports** and double-click a message to open it.
2. Click the **Report** tab.



3. Click **Mail Merge**



   Optionally, click **Preview** to view the merge letter and **Close** to return to Print Mail Merge.

4. Select a *Printer*, *Location* and *Template* and click **OK** to print the letters for the patients listed in the report results.

For detailed instructions for using the *Report* tab, refer to *Report Results* in the ***Reporting Module*** manual.

Internet from Inside HealthMatics EMR

HealthMatics EMR provides the ability to access the Internet from within the product and bookmark favorite sites. If your computer has access to the Internet via a network connection, do the following:

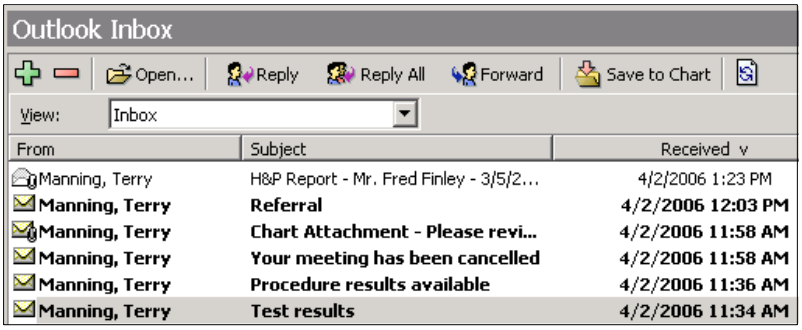
On the HealthMatics EMR toolbar, click ***or*** on the menu bar, select **Launch > Internet Browser**.

Electronic Medical Record Software A4 Health Systems - Microsoft Internet Explorer
File Edit View Favorites Tools Help
Back Search Favorites
Address http://www.a4healthsystems.com/
Go Links
HOME | CONTACT US | CLIENT SITE LOGIN
A4 HEALTH SYSTEMS
NOW PART OF ALLSCRIPTS
Authorized Access Anywhere Anytime
COMPANY | SOLUTIONS | CLIENT SUPPORT | RESOURCES | SPECIALTIES | NEWS & EVENTS | CONTACT US
Latest News
Allscripts Completes Acquisition of A4 Health Systems...
A4 Health Systems Releases New, Fully Integrated EMR & Practice Management System...
Leading Hospitals
About A4 Health Systems
A4 represents Authorized Access, Anywhere, Anytime.
Led by its HealthMatics®, Canopy® and EmSTAT solutions, A4 provides healthcare IT solutions for physician practices and hospitals to streamline the delivery of patient care and to improve bottom-line results.
Solutions
HealthMatics Office
Electronic Medical Record Solution (EMR) and Practice Management System (PMS)
HealthMatics EMR
Electronic Medical Record Solution
HealthMatics Ntierprise
Practice Management System (PMS)
Internet

Outlook Inbox

1. To access Outlook mail from within HealthMatics EMR, do **one** of the following:

   - From the toolbar or the left pane on HealthMatics EMR desktop, click ***or***
   - From the menu bar, select **Office > Outlook Mailbox**.
     If you are set up to access Outlook from HealthMatics EMR, the email view displays messages (if any) in your Outlook Inbox.



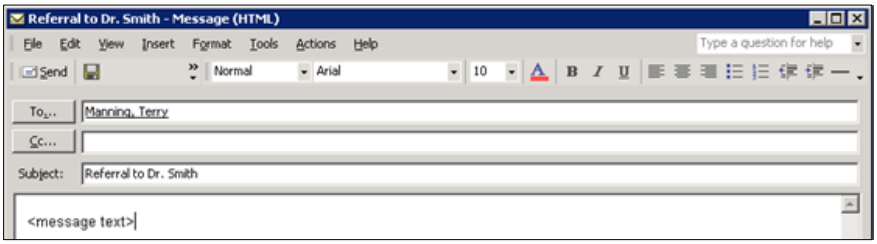
2. Double-click an item to view it or select it and click **Open**.

   NOTES
   ***** To view a list of Outlook emails that you sent, click the **View** down-arrow and select *Sent Items*.

   * The **Delete, Reply, Reply All, Forward** functions are identical to Microsoft Outlook functions.

Creating Outlook emails in the EMR

1. From the Outlook Inbox, on the secondary toolbar, click (New Mail Message).

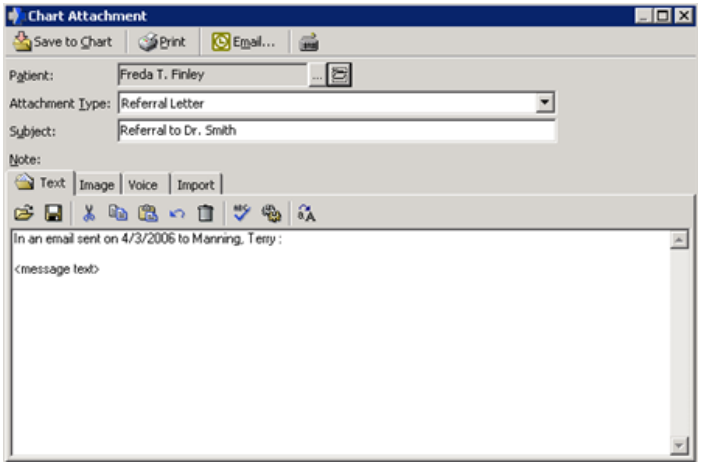


2. In the Message dialog box, select the recipient and subject, enter your message text and click **Send**.

   A Confirm message asks if you want to save the message to a patient's chart.

   - Click **No** if the message does not need to be saved to a chart ***or***

- Click **Yes** to save the message to a chart as an attachment.

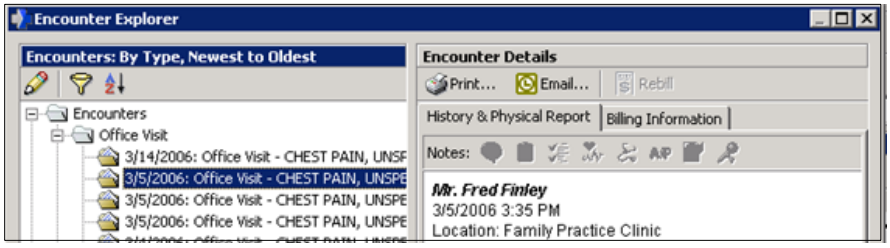


3. In Chart Attachment, click to use the current chart ***or*** to search for another patient.
4. Click the **Attachment Type** down-arrow to select the appropriate designation (how it is filed or stored in the patient's chart).
5. Enter additional information on any of the *Note* tabs, if desired, and click **Save to Chart**.

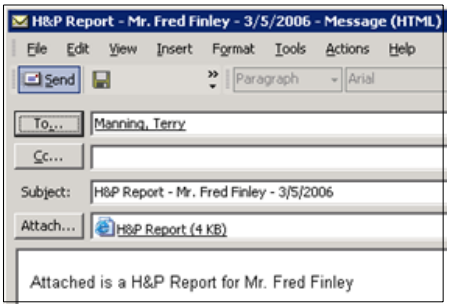
Emailing H&P reports from face sheets

From the *Encounters* pane, you can email H&P reports.

1. Open a chart and from the patient's face sheet ( ), click (View Encounter).
2. In the left pane, select the appropriate office visit to view the H&P Report.



3. Click (Email H&P Report).



The system generate the *Subject* line and text message, and attaches the *H&P Report* automatically.

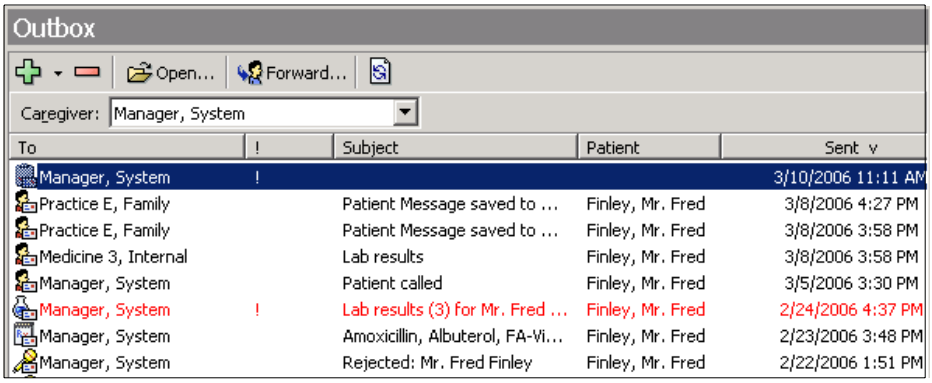
4. At *To*, enter the recipient for the email, add additional text to the message if desired, and click **Send**.

5. In the Confirm box that displays, click **No** if you do not want to save the message to the patient's chart; otherwise, click **Yes** to display Chart Attachment.
For additional information, see Creating Outlook emails in the EMR on page 85).

Outbox

Items in your outbox reflect messages you have sent to other caregivers that have **not yet been opened**. When a recipient opens a message, it automatically deletes from your outbox. Use this feature to determine if others have read your messages. Deleting a message still in your outbox also deletes it from the recipient's inbox.

1. **To access your outbox**, in the left pane of the HealthMatics EMR desktop click (Outbox) ***or*** from the menu bar, select **Office > Outbox**.


Outbox
Open...
Forward...
Caregiver: Manager, System
To
!
Subject
Patient
Sent
Manager, System ! 3/10/2006 11:11 AM
Practice E, Family Patient Message saved to ... Finley, Mr. Fred 3/8/2006 4:27 PM
Practice E, Family Patient Message saved to ... Finley, Mr. Fred 3/8/2006 3:58 PM
Medicine 3, Internal Lab results Finley, Mr. Fred 3/8/2006 3:58 PM
Manager, System Patient called Finley, Mr. Fred 3/5/2006 3:30 PM
Manager, System ! Lab results (3) for Mr. Fred ... Finley, Mr. Fred 2/24/2006 4:37 PM
Manager, System Amoxicillin, Albuterol, FA-Vi... Finley, Mr. Fred 2/23/2006 3:48 PM
Manager, System Rejected: Mr. Fred Finley Finley, Mr. Fred 2/22/2006 1:51 PM

NOTE: Your outbox can contain copies of the following types of items that you sent to yourself or others:
* Lab, procedure, or referral result notifications
* Chart messages accompanying charts
* Mail or patient messages
* Action items
* Refill requests
* Documents (transcription and scanned)

2. Click secondary toolbar icons or right--click for a drop-down menu to perform the following tasks:

Icon	Name	Action
	New (**Insert**)	Create new *Patient Message, Refill Request, Mail Message, Action Item*, or *Web Messages*.
	Delete Message (**Del**)	Delete a selected message from your outbox and the recipient's inbox). **NOTE:** You cannot delete refill requests.
	Open Message (**Ctrl+O**)	View a selected message and reply, forward, print, delete, or forward it to other caregivers.
	Forward Message (**Ctrl+F**)	Forward a selected message to another caregiver.
	Refresh Outbox (**F5**)	Display new items received if you cannot wait until the screen refreshes itself automatically.

3. **To view other caregiver outboxes** - If you have been granted access by other caregivers (see Editing grants on page 129), click the **Caregiver** down-arrow and select the caregiver's name.

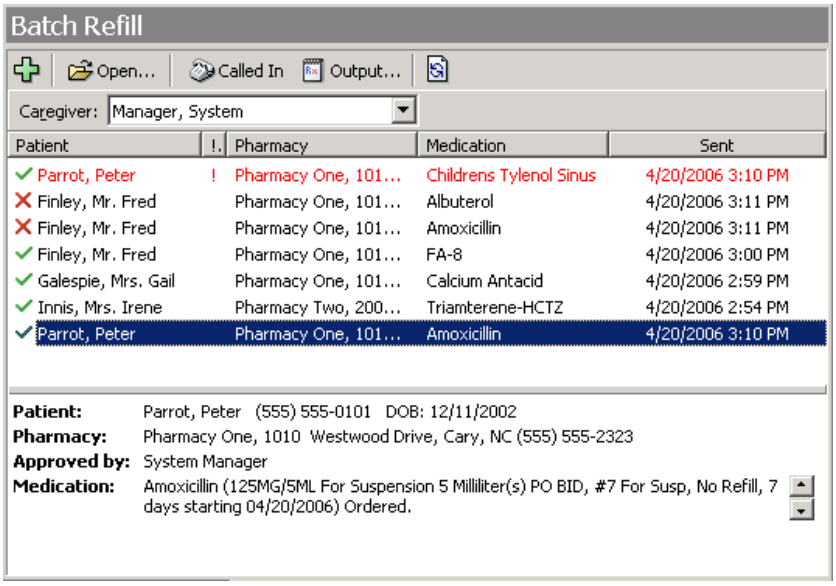
NOTE: You are now viewing the outbox of that caregiver and can perform the same tasks that you can in your own outbox. **Be sure to change the name back to your own when you are done**.

Batch Refill

Batch Refill displays a list of all approved or rejected refill requests awaiting processing. The Rx Manager prints, calls, faxes, or transmits approved refills to pharmacies, and then clicks the appropriate button to indicate the action taken. The refills are then saved to the chart, which documents the action taken in the *Encounter*s pane of the patient's face sheet.

Processing refill requests in batch refill

1. To access *Batch Refill*, from the HealthMatics EMR menu bar, select **Office > Batch Refill *or*** in the left pane of the HealthMatics EMR desktop, click **Batch Refill**.


Batch Refill
Open...
Called In
Output...
Caregiver: Manager, System
Patient | ! | Pharmacy | Medication | Sent
Parrot, Peter ! Pharmacy One, 101... Childrens Tylenol Sinus 4/20/2006 3:10 PM
Finley, Mr. Fred Pharmacy One, 101... Albuterol 4/20/2006 3:11 PM
Finley, Mr. Fred Pharmacy One, 101... Amoxicillin 4/20/2006 3:11 PM
Finley, Mr. Fred Pharmacy One, 101... FA-8 4/20/2006 3:00 PM
Galespie, Mrs. Gail Pharmacy One, 101... Calcium Antacid 4/20/2006 2:59 PM
Innis, Mrs. Irene Pharmacy Two, 200... Triamterene-HCTZ 4/20/2006 2:54 PM
Parrot, Peter Pharmacy One, 101... Amoxicillin 4/20/2006 3:10 PM
Patient: Parrot, Peter (555) 555-0101 DOB: 12/11/2002
Pharmacy: Pharmacy One, 1010 Westwood Drive, Cary, NC (555) 555-2323
Approved by: System Manager
Medication: Amoxicillin (125MG/5ML For Suspension 5 Milliliter(s) PO BID, #7 For Susp, No Refill, 7 days starting 04/20/2006) Ordered.

NOTES

***** To sort the refills, click the column headings.

* To view refills awaiting processing by other refill managers, click the **Caregiver** down-arrow. Security assures that refills can only be processed by the *Rx Manager* designated at the time the refill was approved, so the list is Read-Only.

2. Highlight a refill and the prescription details display in the preview pane at the bottom of the screen.

NOTES

***** Refills marked *High Priority* display in **red** with an exclamation mark in the [**!**] column.

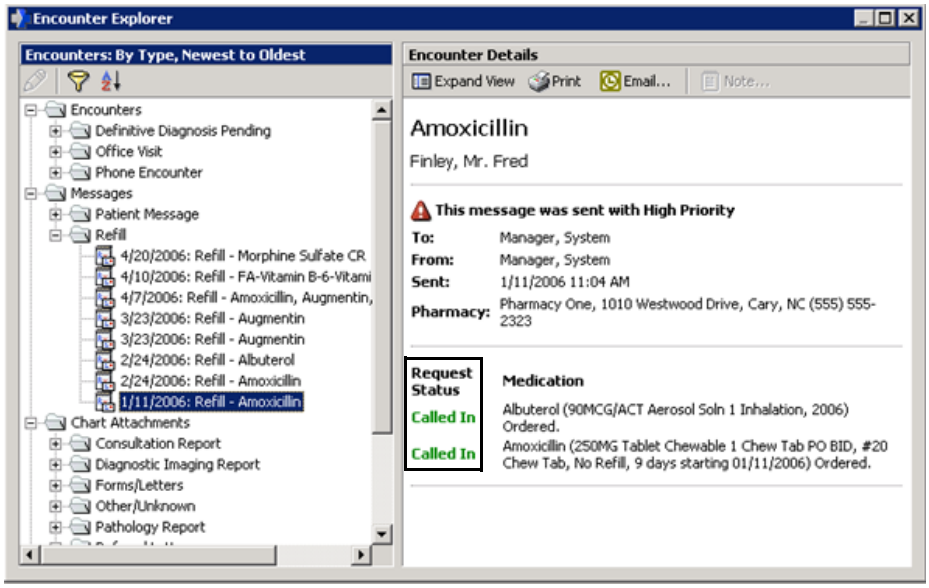
***** If the refill request was rejected, only the name of the medication displays.

* To view the Refill Request dialog for additional details, on the secondary toolbar, click **Open** (see Sending refill requests on page 44).

3. Process the refill by doing **one** of the following:
   - Call the prescription in to the pharmacy (or the patient, if the refill was rejected) and click **Called In *or***
   - Click **Output** to open the Prescription Properties dialog box, from which you can print, fax, or electronically transmit the prescription (see Using prescription properties on page 51).

Viewing refill documentation on face sheets

1. Pull a patient's chart to access the face sheet ( ).
2. In the *Encounters* pane, click (View Encounter).
3. On the toolbar, click to filter *By Type*.
4. Under Messages, click the plus (**+**) sign to open the *Refill* folder.
5. Highlight a refill to view the details and the *Request Status* to the right.



Status	Description
Called In	The refill request was approved by the caregiver and marked called in.
Printed	The refill request was approved by the caregiver and printed.
Faxed	The refill request was approved by the caregiver and faxed.
Transmitted	The refill request was approved by the caregiver and transmitted electronically.

Status	Description
Rejected	The refill request was rejected by the caregiver and saved to the chart.
Filed	The refill request was approved by the caregiver and saved to the chart without being printed, faxed, transmitted, or marked called in.

NOTES

- If the caregiver who requested the refill entered text in the *Refill Request* text box, it displays as a *Note* at the bottom of the Batch Refill screen.
- When printing, the prescription template used is for the caregiver who approved the medication.
- By approving requests and sending them to the Rx Manager, caregivers implicitly give their consent to use their signatures.
- If a faxed prescription has not yet gone through, a *Fax Pending* status displays in both the *Medication* pane of the patient's face sheet and in the Output Queue. If the fax fails, the notice contains the name of the pharmacy, along with the medication name, patient name, and fax number (see Output Queue on page 92).
- You can create a new refill request from Batch Refill by clicking (New Refill Request) ***or*** by pressing **Insert** on your keyboard.

Output Queue

To provide efficient workflow and security, all output documents (excluding Web messages, eRefills, and other documents outputted immediately at the point of care), pass through Output Manager and are recorded in the Output Queue. These documents can be printed, faxed, or transmitted from the Multiple Output dialog box during Sign-Off, or queued directly to the Output Queue. All documents in the Output Queue can be reprinted or refaxed, or just saved to the queue (log), if no paper copy is required. The Output Queue provides an audit trail of actions taken on documents.

From the Output Queue, you can do any of the following:

- Generate new documents that pull information by *Location, Patient*, and *Encounter*.
- View items that have been printed, faxed, or transmitted electronically.
- Reprint or refax failed documents.
- Save documents that do not have to be printed to the log.
- Export documents to a file, which can then be emailed to another caregiver.

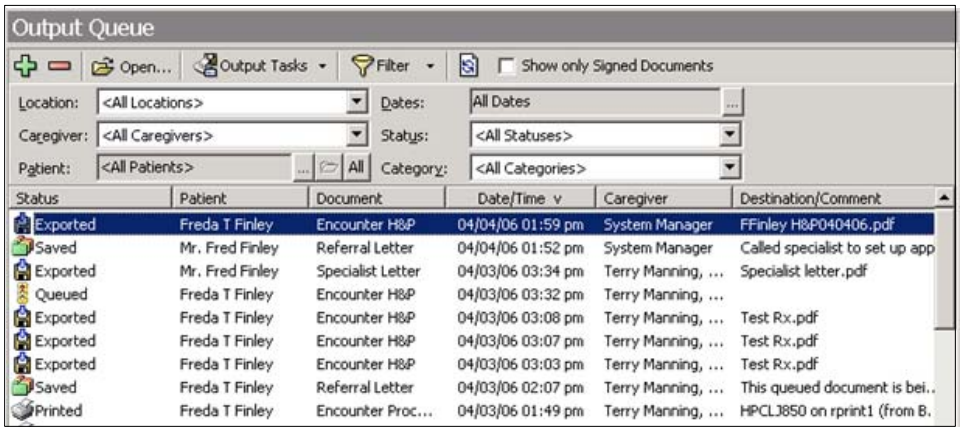
Security - Output Queue security allows you to access documents for patients for whom you have chart access. If you try to open an item for which you do not have access, an *Access Denied* message appears.

Electronic prescriptions - IF you have purchased ePrescribe, the Output Queue also lists prescriptions transmitted from the Multiple Output dialog at Sign Off. Therefore, if an electronic prescription fails to transmit, you can print or fax it from the queue.

NOTE: Electronic prescriptions generated immediately by clicking an **ePrescribe** button do **not** pass through Output Manager and, therefore, are not listed in the Output Queue. (This is also true for Web messages and eRefills.)

Viewing documents from the output queue

1. From the left pane of the HealthMatics desktop or from the **Office** menu bar, select (Output Queue).


Output Queue
Open...
Output Tasks
Filter
Show only Signed Documents
Location: <All Locations>
Dates: All Dates
Caregiver: <All Caregivers>
Status: <All Statuses>
Patient: <All Patients>
All
Category: <All Categories>
Status | Patient | Document | Date/Time | Caregiver | Destination/Comment
Exported | Freda T Finley | Encounter H&P | 04/04/06 01:59 pm | System Manager | FFinley H&P040406.pdf
Saved | Mr. Fred Finley | Referral Letter | 04/04/06 01:52 pm | System Manager | Called specialist to set up app
Exported | Mr. Fred Finley | Specialist Letter | 04/03/06 03:34 pm | Terry Manning, ... | Specialist letter.pdf
Queued | Freda T Finley | Encounter H&P | 04/03/06 03:32 pm | Terry Manning, ... |
Exported | Freda T Finley | Encounter H&P | 04/03/06 03:08 pm | Terry Manning, ... | Test Rx.pdf
Exported | Freda T Finley | Encounter H&P | 04/03/06 03:07 pm | Terry Manning, ... | Test Rx.pdf
Exported | Freda T Finley | Encounter H&P | 04/03/06 03:03 pm | Terry Manning, ... | Test Rx.pdf
Saved | Freda T Finley | Referral Letter | 04/03/06 02:07 pm | Terry Manning, ... | This queued document is bei..
Printed | Freda T Finley | Encounter Proc... | 04/03/06 01:49 pm | Terry Manning, ... | HPCLJ850 on rprint1 (from B.

NOTE: Documents in the queue can have any one of five statuses:

Icon	Name	Description
	Printed	The document was printed.
	Faxed	The document was faxed.
	Saved	The document was saved to the Output Queue Log. Only documents with a status of *Queued* can be *Saved to Log*.
	Export	The document was exported to a file. It may or may not have been previously printed, faxed, or saved to the log.
	Queued	The document was sent to the Output Queue and is awaiting further action.

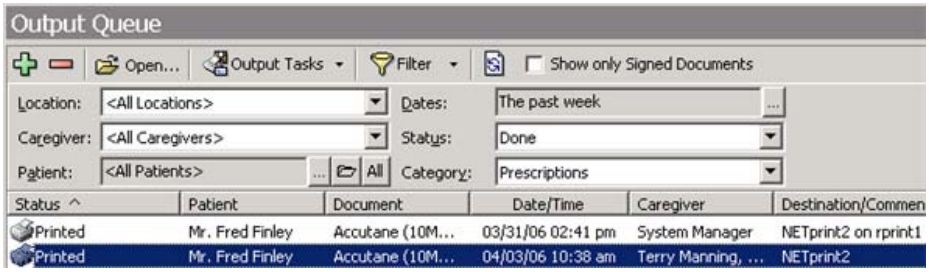
You can click icons on the secondary toolbar to do any of the following:

Icon	Name	Action
	Add document to queue (**Insert**)	Open Add Output Template to generate new output.
	Delete (**Delete**)	Delete a selected document. **NOTE:** You can only delete a document with the *Status* of *Queued*.
	Open	Open a selected document.
	Output tasks	Open a drop-down menu of tasks you can perform for a selected document: • **Electronic Signature** - Add an electronic signature. • **Print** - Print or reprint a document. • **Fax** - Fax or refax a document. • **Save to Log** - Enter a comment and save a document with a status of *Queued* to the log. • **Export** - Export a document to a file.
	Filter	Open a list of quick filters that you've set up (see Quick Filters on page 98).
	Refresh (**F5**)	Refresh the screen to bring in the most recent data.
	Show only Signed Documents	Select the box to display only documents with electronic signatures.

2. To locate an output document, click Filter on the secondary toolbar and select a quick filter ***or*** do the following:
   - Click the **Location** and **Caregiver** down-arrows and make selections.
   - Click a **Patient** button:
     > ... to search for a patient (see Patient Search on page 14) ***or***
     > to select the current patient ***or***

> All to select all patients.

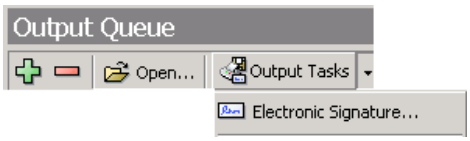
- Click the **Dates** search button and select a date range.
- Click the **Status** down-arrow and select either *<All Requiring Action> <All Statuses>, Done*, or *Faxing*.
- Click the **Category** down-arrow and select the category of the output for which you are searching.



3. Select an item to enable the toolbar icons.

Adding electronic signatures from output queue

1. Access Output Queue and locate and select a document that requires an electronic signature (see Viewing documents from the output queue on page 92).
2. On the secondary toolbar, click (Output Tasks) and select **Electronic Signature**.



Printing from the output queue

1. Access Output Queue and locate and select the document you want to print (see Viewing documents from the output queue on page 92).
2. On the secondary toolbar, click (Output Tasks) to display a drop-down menu. and select **Print**.

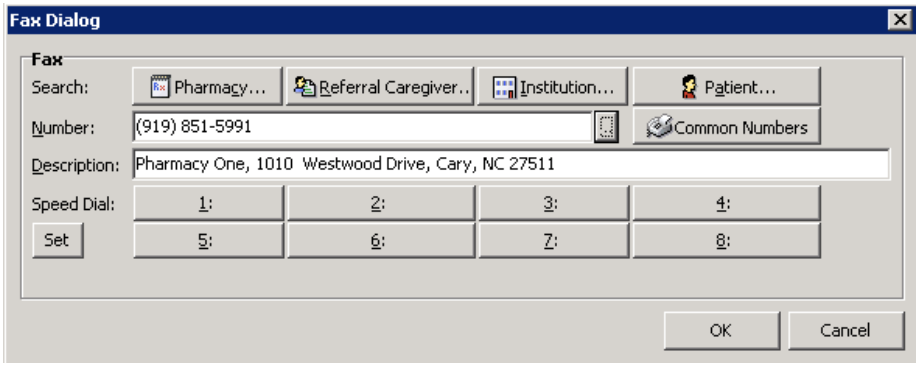
   NOTE: If reprinting a prescription, enter a reason and click **OK**.
3. Click the **Name** down-arrow and select a printer, then click **OK**.

An entry displays for the regenerated document in the Output Queue.

Faxing from the output queue

1. Access Output Queue and locate and select the document you want to fax (see Viewing documents from the output queue on page 92).
2. On the secondary toolbar, click (Output Tasks) to display a drop-down menu. and select **Fax**.

NOTE: If refaxing a prescription, enter a reason and click **OK**.



3. Enter the appropriate information and click **OK** (for detailed instructions, see Printing and Faxing on page 377).

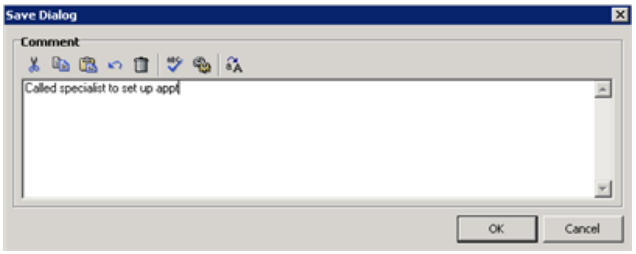
The document displays in the Output Queue with a *Status* of *Faxed*.

NOTE: You can assign access for refaxing or reprinting prescriptions either by individual caregiver or by caregiver type (refer to the ***Administration Module*** manual for instructions).

Saving to log

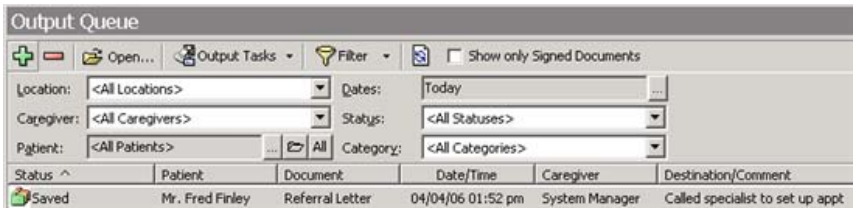
To provide an audit trail for documents that don't necessarily have to be printed, faxed, or transmitted, you can save them directly to the Output Queue log. To save a document to the log, it must have a status of *Queued*.

1. Access Output Queue and locate and select a document with a status of *Queued* ( ) (see Viewing documents from the output queue on page 92).
2. On the secondary toolbar, click (Output Tasks) to display a drop-down menu. and select ( ) **Save to Log**.



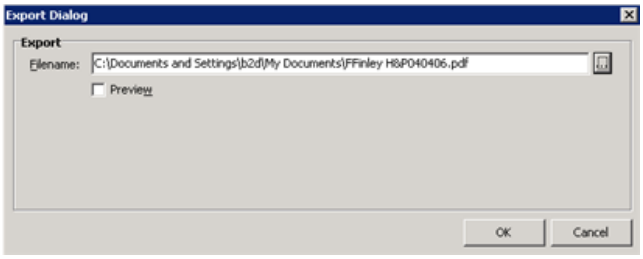
3. In the Save Dialog, enter an optional *Comment* and click **OK**.

The document displays in the Output Queue as *Saved*. You can double-click it and then click the **Action History** tab to view the comment added.



Exporting from output queue

1. Access Output Queue and locate and select the document you want to export (see Viewing documents from the output queue on page 92).
2. On the secondary toolbar, click (Output Tasks) to display a drop-down menu. and select **Export**.
3. In the Export Dialog, click the **Filename** search button to navigate to the directory where you want to store the document, enter a *File Name* and click **Save** to return to Export Dialog.



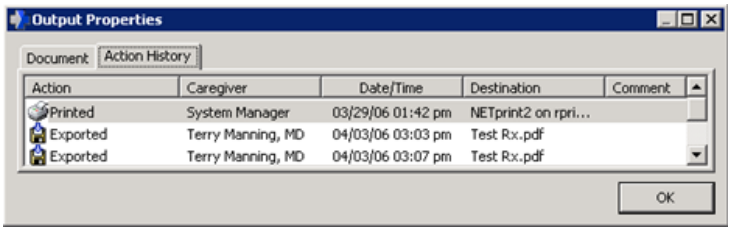
NOTE: To view the document in an Acrobat Reader window, select **Preview** and click **OK**.

4. Click **OK** to export the document to a file.
The document appears in Output Queue with a status of *Exported*.

Viewing output queue action history

1. Access Output Queue, locate and select the document (see Viewing documents from the output queue on page 92).
2. Open the document by doing one of the following:
   - Double click it ***or***
   - Select it and click (Open) ***or***
   - Right-click it and select **Open**.

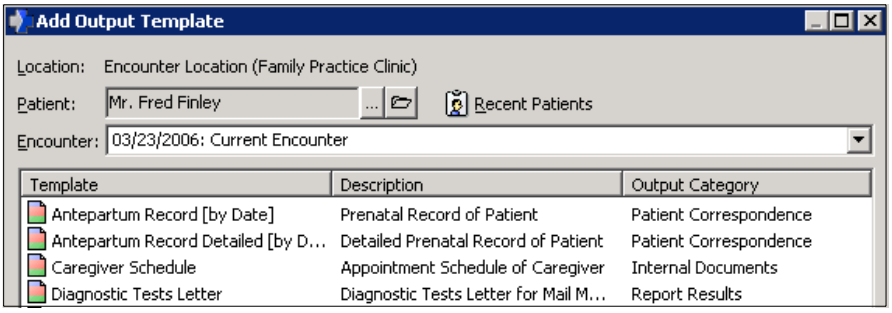
3. Click the **Action History** tab to see the following:



- Action taken
- Caregiver who took the action
- Date and time action was taken
- Destination - Printer or other output device used
- Comment, if any was entered

Creating new output from the output queue

1. In the Output Queue view, press **Insert** on your keyboard ***or*** click (Add Document to Queue) to display a list of all available output templates.



2. At *Patient*, select a patient by doing **one** of the following:
   - Click to search for a patient.
   - Click (Use Current Chart) to select the current patient ***or***
   - Click (Recent Patients) to view a list of patient charts recently accessed ***or***
3. Click the **Encounter** down-arrow and select an encounter to which to attach the document.
4. Select the **Template** from the list and click **OK** to open the Print dialog box.

   NOTE: If a dialog box displays, make the appropriate selections and click **OK** to access the Print screen.
5. From the Print dialog, *Print, Fax, Queue, Save to Log, Export* or *Preview* the document (for instructions, see Printing and Faxing on page 377).

Quick Filters

Quick filters provide the ability to filter lists of items based on multiple criteria, using a single click. These filters can be customized for each user.

Quick filters are available on the secondary toolbar of all the following **Clinical Module** screens:

- Lab Results
- Procedure Results
- Additional Results
- Output Queue
- Input Manager

You can set two different sets of quick filters -- one set for use when you have a chart pulled, and set for use when no charts are pulled. The system knows the difference and displays the appropriate set of quick filters that you set for each.

Creating quick filters

To create and use a quick filter, on any secondary toolbar where the toggle filter button (with down-arrow

) displays, do the following with, or without a chart pulled:

1. Set the *Patient, Dates*, and *Status*, and *Sort* to one set of commonly used criteria for locating documents.

   Examples:
   * All Patients, The Past Week, All Statuses
   * All Patients, All Dates, All Requiring Action
   * All Patients, All Dates, Ready for Indexing
   * All Patients, All Dates, Needs Review, Oldest to Newest

2. On the secondary toolbar, click and select **Set Filter > #1** to display Set Quick Filter #1.

3. At *Name*, type a name for your filter and click **OK**.

4. To set another quick filter, select the new filters in the search fields and, on the toolbar, click again, select **Set Filter > #2** enter a name for the new filter and click **OK**.

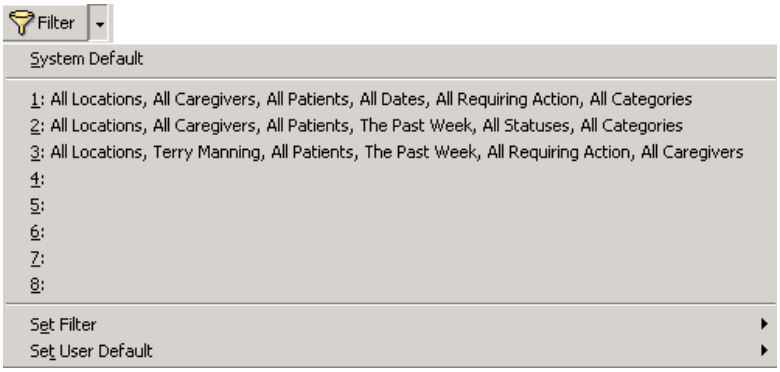
5. Repeat this process to set up to eight quick filters.

Setting user defaults for quick filters

You can set two different default quick filters -- one for the filters you use most often when working in a patient's chart, and one for the filters you use most often when no chart is pulled (**Example:** you are entering lab results on multiple patients or reviewing results on multiple patients at one time).

1. With no chart open, set a quick filter (see Creating quick filters on page 98) with the search criteria that you use most commonly when **not** in a patient chart (**Example:** All Patients, The past month, Ordered, Oldest to Newest, and name the quick filter "Results Entry").

2. To set the no-chart user default quick filter click to display the quick filters you've set up,


Filter
System Default
1: All Locations, All Caregivers, All Patients, All Dates, All Requiring Action, All Categories
2: All Locations, All Caregivers, All Patients, The Past Week, All Statuses, All Categories
3: All Locations, Terry Manning, All Patients, The Past Week, All Requiring Action, All Caregivers
4:
5:
6:
7:
8:
Set Filter
Set User Default

NOTE: *System Default* is the original filter settings for *Patient, Dates, Status*, and *Sort*.

3. Select **Set User Default** and the filter that you want as your default when you open the screen.

4. Open a patient's chart and repeat the preceding steps to set a quick filter with the search criteria that you use most commonly when you **are** in a patient's chart (**Example:** The past 3 months, Needs Review, Oldest to Newest, and name the quick filter "Review."

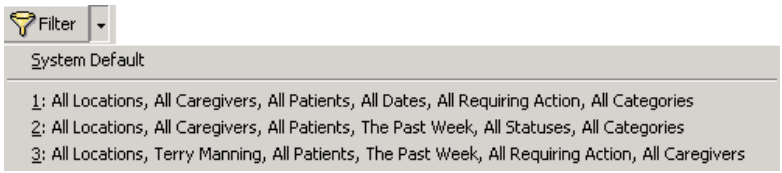
When no chart is open on your desktop and you click , the appropriate filters set by default.

Using quick filters

NOTE: For instructions for setting up quick filters, see Creating quick filters on page 98,

On any screen where you have set up quick filters to search lists of items using multiple criteria, do the following:

1. On the secondary toolbar, click .


Filter
System Default
1: All Locations, All Caregivers, All Patients, All Dates, All Requiring Action, All Categories
2: All Locations, All Caregivers, All Patients, The Past Week, All Statuses, All Categories
3: All Locations, Terry Manning, All Patients, The Past Week, All Requiring Action, All Caregivers

1. Look at the descriptions of the filters and click the one you want to use to locate the item you need.

NOTE: You can also click **System Default** at any time to return to the original filter settings:
* Caregiver - user logged in
* Patient - All Patients
* Dates - The past 6 months
* Status - Ordered
* Sort - Newest to Oldest

Worklogs

In HealthMatics EMR, use the worklog to meet HIPAA requirements for auditing and tracking chart contact and caregiver activity. The worklog also captures failed logins where a valid *Login Name* was entered.

- **Uses for worklogs**
  - > Review and manage multiple caregivers' patient workloads.
  - > Determine which caregiver last saw a patient on a specified date.
  - > Review the productivity of caregivers.
  - > Track which machine a user logged into, as well as which charts were accessed from a specific machine.
  - > Track which contact screens were documented for a specific chart by a specific user.
  - > Print a worklog report.
  - > View encounter information from *Appointments*.
- **Generation** - The worklog is automatically generated and updated.
- **Manipulation** - Resize the columns or re-order them by dragging and dropping the headings.

You can filter information using any of three methods:

- **Caregiver** - Use the *Caregiver* worklog to display a list of scheduled and unscheduled events that occur on a specified date for a particular caregiver, including charts pulled and/or reviewed.
- **Machine** - Use the *Machine* worklog to display all contact with patient charts made from a specific machine.
- **Patient** - Use the *Patient* worklog to display all contact made with an individual patient's chart for one date or all dates.

NOTE: Assign the privilege to access worklogs in the **Administration Module**, either by *Caregiver*, or by *Function Access*. Set *Access* to *None* or *Read Only*. For instructions, refer to the ***Administration Module*** manual.

Tracking chart contact using worklogs

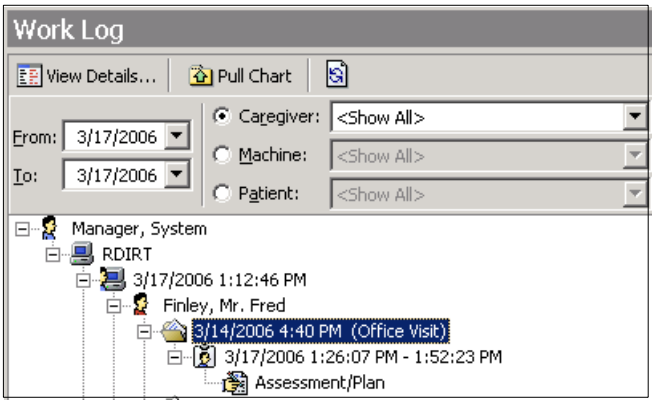
Contacts that did not have associated saved data display the message, <*Chart reviewed without edits*>. Contacts that did include saved data display the message, *Edited <screen name>*.

1. From the left pane or the **Office** menu, select (Worklog).
2. Click the **From** and **To** down-arrows to select a date range for the activity you would like to view.
3. Select a filter:
   - **Caregiver** - Displays contact made to patient charts by caregiver.
   - **Machine** - Displays contact made to patient charts at a workstation.

- **Patient** - Displays all contact made to a selected patient's chart.

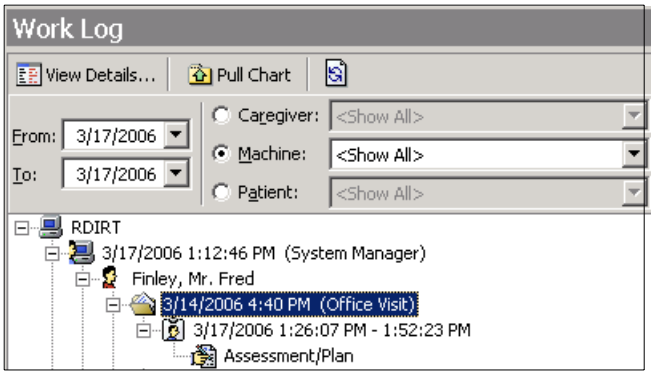
4. In the preview pane, click (**+**) signs as needed to view the areas of the worklog.
5. Select an item at the encounter level (3/5/2006 3:35 PM (Review)) and click (View Details) to display it in an Explorer window.

Filter by caregiver



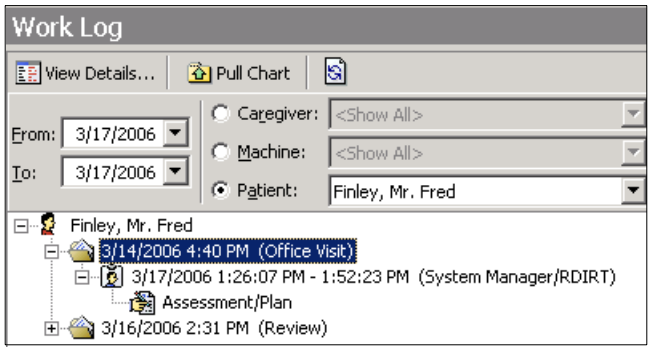
Tree Level	Description of information
Level 1	**Logins** - Caregivers logged in during the date range selected, including the times logged in and out. **NOTE:** If the caregiver is still logged in, no logout time displays.
Level 2	**Servers** - Servers used during the date range selected
Level 3	**Dates** - Dates and times caregiver logged. Includes log out times unless the caregiver is still logged in.
Level 4	**Patients** - Patient charts the caregiver opened during the date range selected. If no charts were accessed during the login, a messages states, *No patients are associated with this login*.
Level 5	**Encounters** - Encounters the caregiver created, including the time the chart was pulled and the encounter type (Office Visit) in parentheses. **NOTE:** Selecting an encounter enables **View Details** on the secondary toolbar.
Level 6	**Contacts** - Start and stop time a caregiver had the chart open before sending it on to another caregiver or filing it **NOTE:** If contacts did not have associated saved data, a message states, *Chart reviewed without edits*.
Level 7	**Contact screens** - Names of contact screens where values were entered. **NOTE:** Screen names display if the caregiver documented on the screen and the values entered were not overwritten by another caregiver in a subsequent contact.

Filter by machine



Tree Level	Description of information
Level 1	**Servers** - Servers used during the date range selected
Level 2	**Logins** - Caregivers logged in during the date range selected, including the times logged in and out. **NOTE:** If the caregiver is still logged in, no logout time displays.
Level 3	**Patients** - Patient charts the caregiver opened during the date range selected. If no charts were accessed during the login, a messages states, *No patients are associated with this login*.
Level 4	**Encounters** - Encounters the caregiver created, including the time the chart was pulled and the encounter type (Office Visit) in parentheses. **NOTE:** Selecting an encounter enables **View Details** on the secondary toolbar.
Level 5	**Contacts** - Start and stop time a caregiver had the chart open before sending it on to another caregiver or filing it **NOTE:** If contacts did not have associated saved data, a message states, *Chart reviewed without edits*.
Level 6	**Contact screens** - Names of contact screens where values were entered. **NOTE:** Screen names display if the caregiver documented on the screen and the values entered were not overwritten by another caregiver in a subsequent contact.

Filter by patient



Tree Level	Description of information
Level 1	**Patients** - Patient charts the caregiver opened during the date range selected. If no charts were accessed during the login, a messages states, *No patients are associated with this login*.
Level 2	**Encounters** - Encounters the caregiver created, including the time the chart was pulled and the encounter type (Office Visit) in parentheses. **NOTE:** Selecting an encounter enables **View Details** on the secondary toolbar.
Level 3	**Contacts** - Start and stop time a caregiver had the chart open before sending it on to another caregiver or filing it **NOTE:** If contacts did not have associated saved data, a message states, *Chart reviewed without edits*.
Level 4	**Contact screens** - Names of contact screens where values were entered. **NOTE:** Screen names display if the caregiver documented on the screen and the values entered were not overwritten by another caregiver in a subsequent contact.

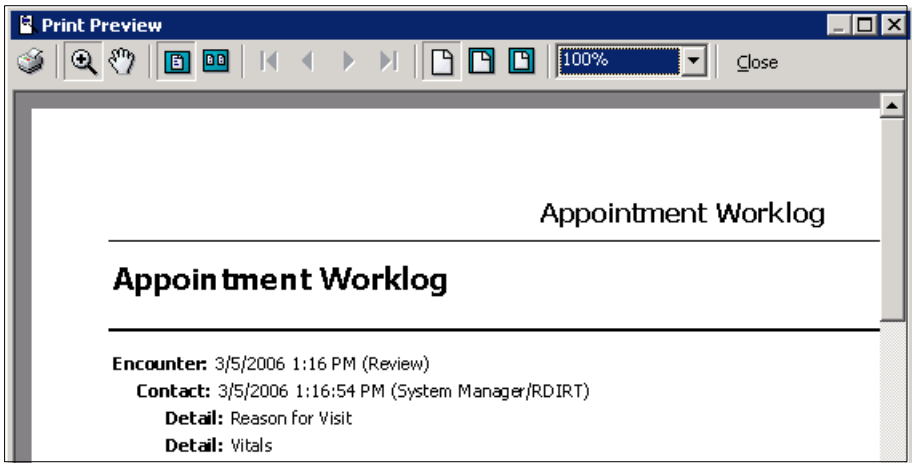
Using the worklog toolbar functions

- **View details** - Click to view the *H&P Report* and *Billing Information*, Patient Message, or Refill Request associated with the selected encounter in the worklog.
- **Pull chart** - With a patient, encounter, or contact in the worklog selected, click to pull the associated chart.
- **Refresh** - Click to update the tree view without changing any of the *Date Range* or *Filter* settings.

Tracking patients during visits

To track the progress of a patient's visit without having to leave the Appointments view, do the following:

1. From the status bar, toolbar or left pane of the HealthMatics EMR desktop, click (Appointments).
2. Right-click any appointment and click (View Worklog) to view contact made with the patient's chart for that visit.

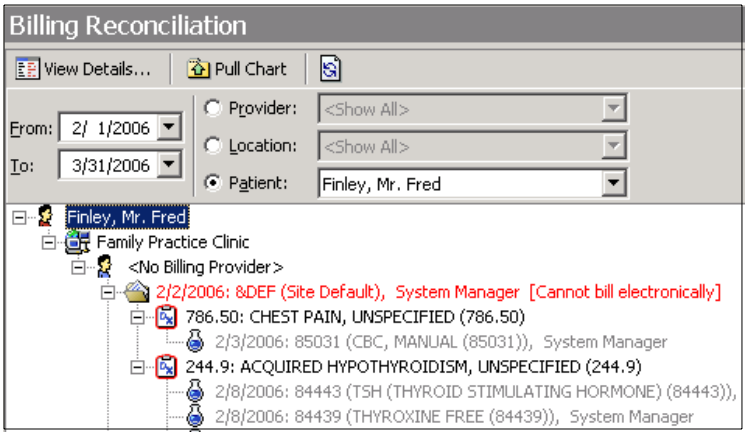


3. To check the progress of the visit, look at *Details* to see where documentation has been entered, then click **Close** to return to *Appointments*.

Billing Reconciliation

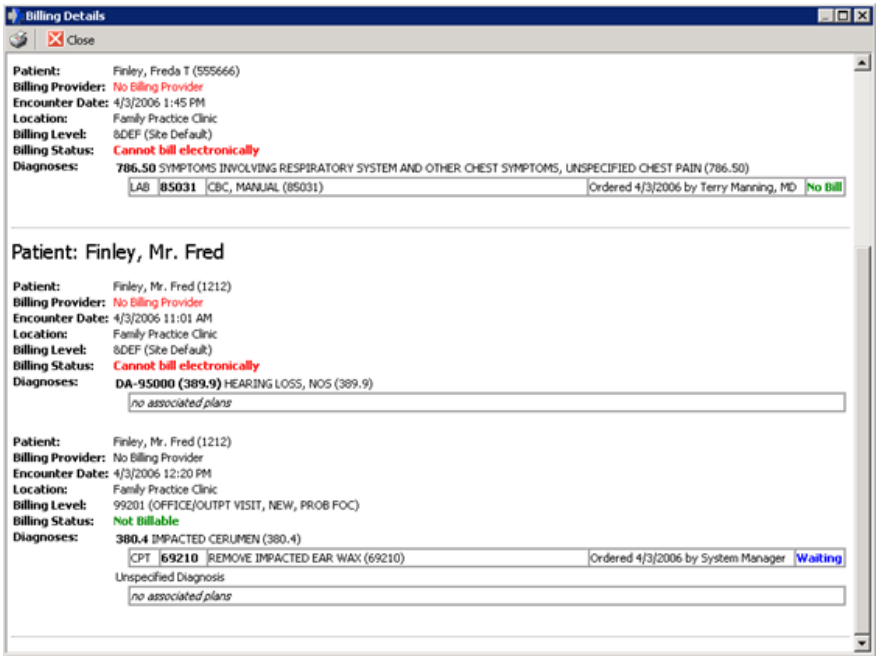
Billing Reconciliation provides a quick way to access billing information for a selected period. You can filter the data by *Provider, Location* or *Patient*

1. To access Billing Reconciliation, do **one** of the following:
   - In the left pane of the desktop, click **Billing Reconciliation *or***
   - From the application menu bar, select **Office > Billing Reconciliation**.



2. In *From/To*, select a date range for the items you want to view.
3. Filter the items, if desired, by selecting **Provider, Location,** or **Patient**, and then clicking the respective down-arrow to make a selection.
   - **Provider** - Filter items by billing provider, location, patient, encounter, contact screen, detail.
   - **Location** - Filter items by location, billing provider, patient, encounter, contact screen, detail.
   - **Patient** - Filter items by patient, location, billing provider, encounter, contact screen, detail
4. Click plus signs (**+**) to expand the folders to reach the level that you need.

- To view billing details, highlight an item and click **View Detail**.


Billing Details
Close
Patient: Finley, Freda T (555666)
Billing Provider: No Billing Provider
Encounter Date: 4/3/2006 1:45 PM
Location: Family Practice Clinic
Billing Level: &DEF (Site Default)
Billing Status: Cannot bill electronically
Diagnoses: 786.50 SYMPTOMS INVOLVING RESPIRATORY SYSTEM AND OTHER CHEST SYMPTOMS, UNSPECIFIED CHEST PAIN (786.50)
LAB 85031 CBC, MANUAL (85031) Ordered 4/3/2006 by Terry Manning, MD No Bill
Patient: Finley, Mr. Fred
Patient: Finley, Mr. Fred (1212)
Billing Provider: No Billing Provider
Encounter Date: 4/3/2006 11:01 AM
Location: Family Practice Clinic
Billing Level: &DEF (Site Default)
Billing Status: Cannot bill electronically
Diagnoses: DA-95000 (389.9) HEARING LOSS, NOS (389.9)
no associated plans
Patient: Finley, Mr. Fred (1212)
Billing Provider: No Billing Provider
Encounter Date: 4/3/2006 12:20 PM
Location: Family Practice Clinic
Billing Level: 99201 (OFFICE/OUTPT VISIT, NEW, PROB FOC)
Billing Status: Not Billable
Diagnoses: 380.4 IMPACTED CERUMEN (380.4)
CPT 69210 REMOVE IMPACTED EAR WAX (69210) Ordered 4/3/2006 by System Manager Waiting
Unspecified Diagnosis
no associated plans

Details display in table form from the selected item on down.

NOTES
* **Cannot bill electronically** - Encounters documented on charts that were not pulled from the *Appointments* schedule, cannot be billed electronically. Billing information for those encounters must be manually entered into the Practice Management System.

*** Billable** - Billable items that aren't pulled from the schedule appear in red, since they cannot be billed electronically.

* **Not-billable** - Items may be non-billable if a non-billable encounter type, such as Historical Summary, was selected at *Sign-Off*.

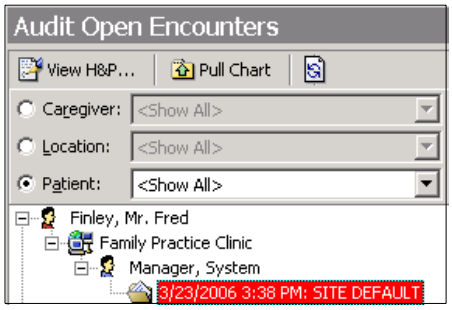
* **Waiting** - Items marked *Waiting* (in blue) result from clicking **Bill** (from *H&P Report*) on an encounter that has not yet been signed off.

5. To print the report, do any of the following:
   - From Billing Details, press **Ctrl+P** or click ***or***
   - From Billing Reconciliation click or press **Ctrl+P** and select **Billing Reconciliation Report**.
6. To view a patient's chart and exit Billing Reconciliation, highlight the patient's name and click **Pull Chart**.

Audit Open Encounters

Audit Open Encounters lists all encounters that have not yet been signed off. You can sort items by *Caregiver, Location*, or *Patient*, and view H&P reports and/or pull charts for the encounters/patients listed.

1. To access *Audit Open Encounters*, do **one** of the following:
   - In the left pane of the desktop, click **Audit Open Encounters *or***
   - From the application menu bar, select **Office > Audit Open Encounters**.



   NOTE: Encounters open more than one week display in **red**.

2. Filter the items, if desired, by selecting **Caregiver, Location,** or **Patient**, and then clicking the respective down-arrow to make a selection.
   - **Caregiver** - Filter items by caregiver, location, patient, encounter.
   - **Location** - Filter items by location, caregiver, patient, encounter.
   - **Patient** - Filter items by patient, location, caregiver, encounter.
3. Click plus signs (**+**) to expand the folders to reach the encounter level.
4. To view the H&P report for the encounter, double-click the encounter or select it and click **View H&P**.

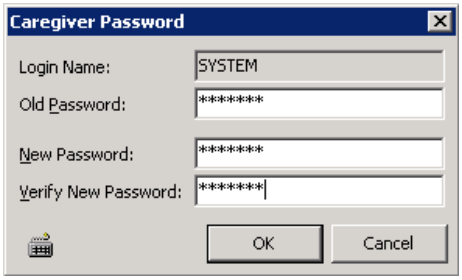
Options

In HealthMatics EMR, you can tailor the way information displays to suit your preferences and needs. From the *Options* menu, you can do all of the following:

- Changing passwords on page 108
- Editing options on page 108
- Editing grants on page 129
- Editing output defaults on page 130
- Editing default locations on page 131
- Editing auto replace text on page 131

Changing passwords

You can change your password at any time. In addition, your system may be set to require password changes at selected intervals.



1. To change your password, from the menu bar, select **Options > Change Password**.
2. Enter the requested password information and click **OK**.

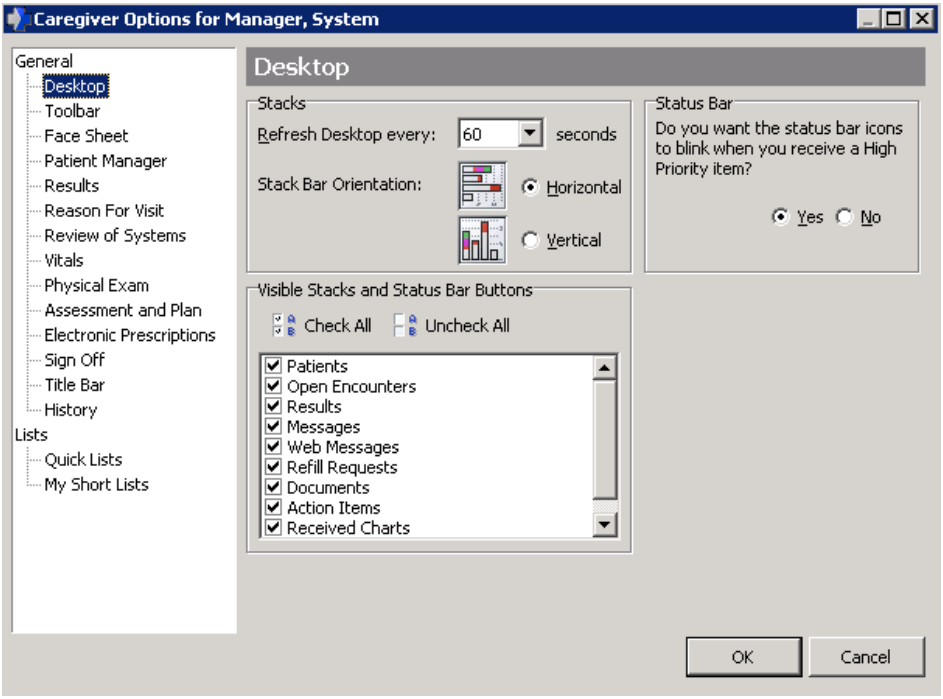
Editing options

You can edit display preferences for many areas of your desktop, toolbar, patient face sheets, *Patient Manager*, lab results, reason for visit, review of systems, vitals, physical exam, assessment and plan, electronic prescriptions, sign off, title bar, history, quick lists, and *My Short Lists*.

NOTE: The system or practice administrator can also set defaults for all caregivers in the **Administration Module**. For instructions, refer to the ***HealthMatics EMR Administration Module*** manual.

To set desktop defaults

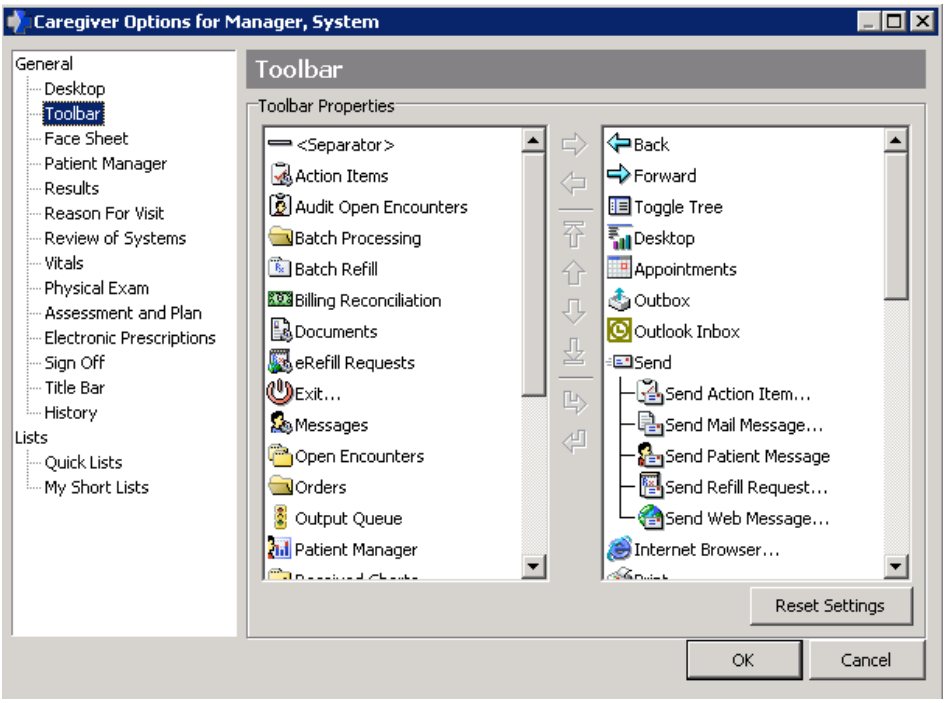
1. From the HealthMatics EMR menu bar, select **Options > Edit Options > Desktop**.



2. **Stacks** - To set defaults for stacks that display in *Office Manager*, do the following:
   - At *Refresh Desktop every*, click the down-arrow and select number of seconds to set frequency for updating stacks and status bar with new data entered.
   - At *Stack Bar Orientation*, click either **Horizontal** or **Vertical**.
3. **Status bar** - Click either **Yes** or **No** to indicate whether you want the status bar icons to blink (red) when you receive a message marked *High Priority* or results that contain abnormal values.
4. **Visible stacks and status bar buttons** - Deselect any stacks or status bar buttons you do not wish to display.
5. Click **OK** to save changes and exit ***or*** select another item in the left pane to set more defaults.

To customize your toolbar

1. From the HealthMatics EMR menu bar, select **Options > Edit Options > Toolbar.**



2. In the *Toolbar Properties* box, select an icon from the list on the left and click (Add Item) to move it to the toolbar list on the right, selecting from any of the icons listed below.

   NOTE: To remove an icon from the toolbar, select it in the right pane and click (Remove Item):

Icon	Name	Action
	<Separator>	Insert a vertical bar to separate groups of icons on your toolbar.
	Action Items	View items sent to your inbox for action.
	Appointments	View scheduled appointments.
A/P	Assessment/Plan	Access the current patient/s Assessment/Plan screen.
	Audit Open Encounters	Track the process of a patient's visit by viewing worklogs of open encounters. Can be filtered by *Caregiver, Location*, or *Patient.*
	Back	Go back to a previously opened view. **NOTE:** Click the down-arrow to see a list of previously selected views from which to select.
	Batch Processing	Process lab requisitions in batches.

Icon	Name	Action
	Batch Refill	View Batch Refill to process multiple refills at once.
	Bill Reconciliation	View billing information by date range for a provider, location, or patient. **NOTE:** Caregivers must have function access to view.
	Chart Attachments	View the current patient's chart attachments.
	Demographics	View the current patient's demographics. **NOTE:** Click the down-arrow to select *Chart Attachments, Immunizations, Flow Sheets*, or *Reminders*.
	Desktop	Access your HealthMatics EMR desktop.
	Documents	List documents sent to your inbox for review.
	eRefill Requests	List eRefill Requests sent to your inbox for approval.
	Exit	Exit HealthMatics EMR.
	Face Sheet	View the current patient's face sheet.
	File Chart	File the current open chart.
	Flow Sheets	View the current patient's flow sheets.
	Forward	Go forward to a previously opened view. **NOTE:** Click the down-arrow to list previously opened views from which to select.
	History	View the current patient's history information.
	HP Report	View the current patient's H&P Report.
	Immunizations	View the current patient's immunization record.
	Internet Browser	Access the Internet (**IF** your practice has Internet access) from within HealthMatics EMR.
	Logout	Log out of the Clinical Module before leaving your workstation.
	Messages	List messages (patient and mail) sent to your inbox.
	Open Encounters	List all your open encounters.
	Orders	List all patients with orders that have not yet been placed on requisitions. **NOTE:** Click (Move Item In) to place *Orders* in a drop-down menu under *Lab Order Entry,* if desired.
	Outbox	View items that you have sent that have not yet been read.

Icon	Name	Action
	Outlook Inbox	Access your Outlook inbox (**IF** your site uses Microsoft Outlook) from within HealthMatics EMR.
	Output Queue	List all documents that you have printed, faxed, or transmitted.
	Patient Manager	Access the Patient Manager view of the current patient's health reminders, and documents, orders and refill requests awaiting your review.
	Physical Exam	Access the Physical Exam screen for the current encounter.
	Print	Output a document (may include printing, faxing, or transmitting).
	Pull Chart	Open a chart for a patient.
	Quick Assessment/ Plan	Access the Assessment & Plan screen for the current encounter.
	Reason for Visit	Access the Reason for Visit screen for the current encounter.
	Received Charts	List charts sent to you by other caregivers.
	Refill Requests	List refill requests sent to you for approval.
	Reminders	List reminders on the current patient's chart.
	Report Results	List reports that have been enabled at your site, along with the last time they have been run and the results.
	Reports	Access report results that have been sent to you for action (**Example:** Patients that need followup calls).
	Requisitions	List requisitions that have been created, but not yet sent. **NOTE:** Click (Move Item In) to place *Requisitions* in a drop-down menu under *Lab Order Entry,* if desired.
	Result Notifications	List result notifications sent to you for review.
	Result Summaries	Access the Result Summaries for the current patient.
	Review of Systems	Access the Review of Systems screen for the current encounter.
	Send	List items that you can create and send: *Web Message, Refill Request, Patient Message, Mail Message,* or *Action Item*. **NOTE:** Click (Move Item In) to place message types in a drop-down menu under *Send*, if desired.

Icon	Name	Action
	Send Action Item	Create a new action item to send to yourself or to another caregiver. **NOTE:** Click (Move Item In) to place *Send Action Item* in a drop-down menu under *Send*, if desired.
	Send Chart	Send the current chart (displayed on the title bar) to another caregiver.
	Send Mail Message	Create a new mail message to send to one or more caregivers. **NOTE:** Click (Move Item In) to place *Send Mail Message* in a drop-down menu under *Send,* if desired.
	Send Patient Message	Create a new patient message to send to another caregiver. **NOTE:** Click (Move Item In) to place *Send Patient Message* in a drop-down menu under *Send,* if desired.
	Send Refill Request	Create a new refill request to send to an approving caregiver. **NOTE:** Click (Move Item In) to place *Send Refill Request* in a drop-down menu under *Send*, if desired.
	Send Web Message	Create a web message to send to a registered patient. **NOTE:** Click (Move Item In) to place *Send Web Message* in a drop-down menu under *Send,* if desired.
	Toggle Tree	Toggle the navigation tree in the left pane on and off.
	View Lab Results	View the current patient's lab results or search for another patient's lab results.
	View Procedure Results	View the current patient's procedure results or search for another patient's procedure results.
	Vitals	Access the Vital Signs screen during a patient encounter.
	Work Log	Access the Work Log screen to view contact made with patient charts by caregivers, by patient, and/or by machine.

3. After selecting all the shortcuts that you want on your toolbar, sort and organize the icons in the right pane by selecting them and clicking the directional arrow buttons described below:

Icon	Name	Action
	Move Item to Top	Move the selected item to the top of the list (far left side of the toolbar).
	Move Item Up	Move the selected item up.
	Move Item Down	Move the selected item down.

Icon	Name	Action
	Move Item to Bottom	Move the selected item to the bottom of the list (far right side of the toolbar).
	Move Item In	Move the selected item into a drop-down menu under the item above. **NOTE:** On the toolbar, access the menu list by clicking a down-arrow to the right of the primary item.
	Move Item Out	Move the selected item out of the primary item's drop-down menu (see above).

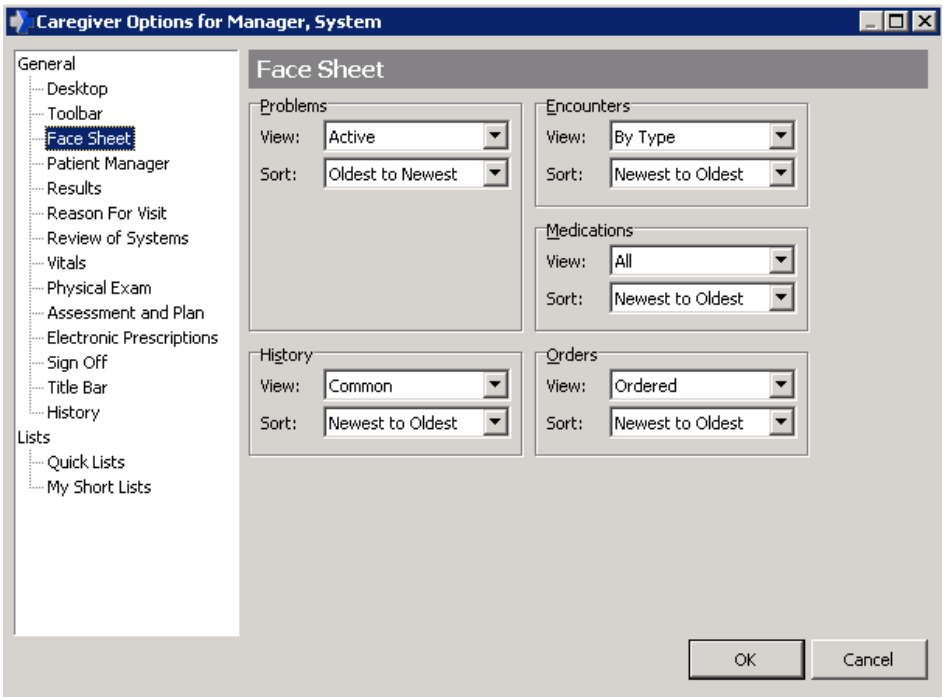
4. To separate groups of related icons, such as *Pull Chart, File Chart(s), Send Chart*), click the arrow icons to place them consecutively in the list on the right, and then insert a Separator (<Separator>) before the first and after the last icon in the group.

5. Click **OK** to exit ***or*** select another item in the left pane to set more defaults.

To set face sheet defaults

You can filter information and set the sort order for each of the five panes on face sheets. The system remembers each caregiver's preferences.

1. From the HealthMatics EMR menu bar, select **Options > Edit Options > Face Sheet**.



2. **Problems**

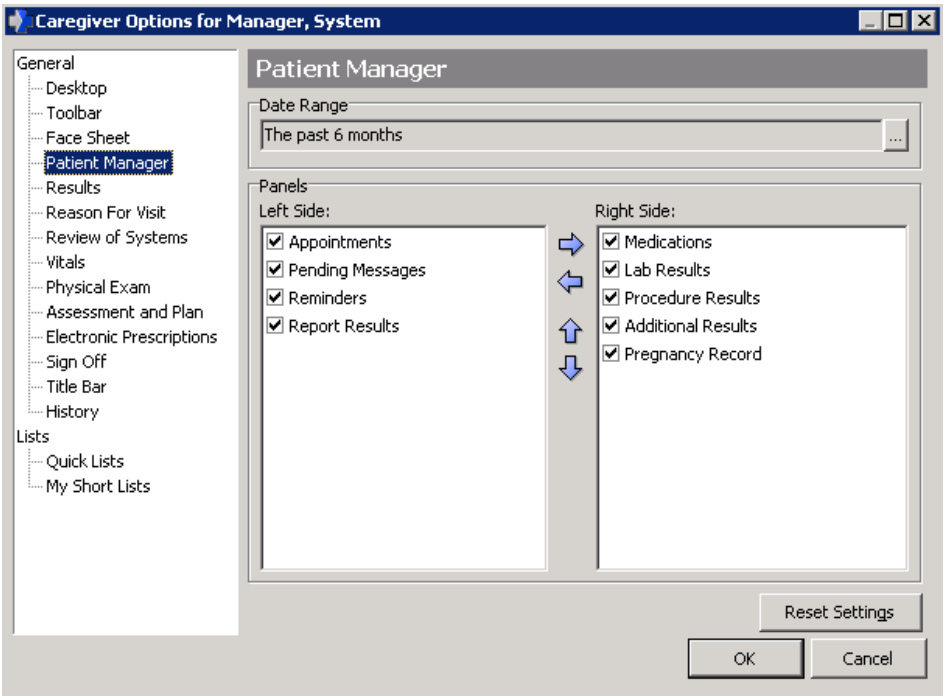
   - Click the **View** drop-down arrow to select the view you want the patient's problems to display by default: *All*, *Active*, *Inactive*, or *Resolved*.

- Click the **Sort** drop-down arrow to select the way you want the patient's problems to sort by default: *Newest to Oldest, Oldest to Newest, Alphabetically*, or by *Acuity*.

3. **History**
   - Click the **View** drop-down arrow to select the way you want the patient's history to display by default: *Full* (all eight categories) *Allergies, Immunizations*, or *Common* (allergies, family, past medical, and social history).
   - Click the **Sort** drop-down arrow to select the way you want the patient's history to sort by default: *Newest to Oldest, Oldest to Newest*, or *Alphabetically*.
4. **Encounters**
   - Click the **View** drop-down arrow to select the way you want the patient's encounters to display by default: *By Date* or *By Type*.
   - Click the **Sort** drop-down arrow to select the way you want the patient's encounters to sort by default: *Newest to Olde*st or *Oldest to Newest*.
5. **Medications**
   - Click the **View** drop-down arrow to select the way you want the patient's medications to display by default: *All, Active, Inactive*, or *Discontinued.*
   - Click the **Sort** drop-down arrow to select the way you want the patient's medications to sort by default: *Newest to Olde*st or *Oldest to Newest,* or *Alphabetically*.
6. **Orders**
   - Click the **View** drop-down arrow to select the way you want the patient's orders to display by default: *All, Pending, Needs Review, Reviewed*, or *Ordered*.
   - Click the **Sort** drop-down arrow to select the way you want the patient's orders to sort by default: *Newest to Olde*st or *Oldest to Newest*.
7. Click **OK** to exit ***or*** select another item in the left pane to set more defaults.

To set patient manager defaults

1. From the HealthMatics EMR menu bar, select **Options > Edit Options > Patient Manager**.



   The *Panels* box displays the list of items that can be included in the Patient Manager view. Selected items will be included.The default view includes all items in a two-column format.

2. Click the **Date Range** search button (...) and select a range of dates ***or*** specific transaction dates for the information you want to display in *Patient Manager*.

3. Determine the items that you want to include in the view, and how they are displayed, by doing the following:

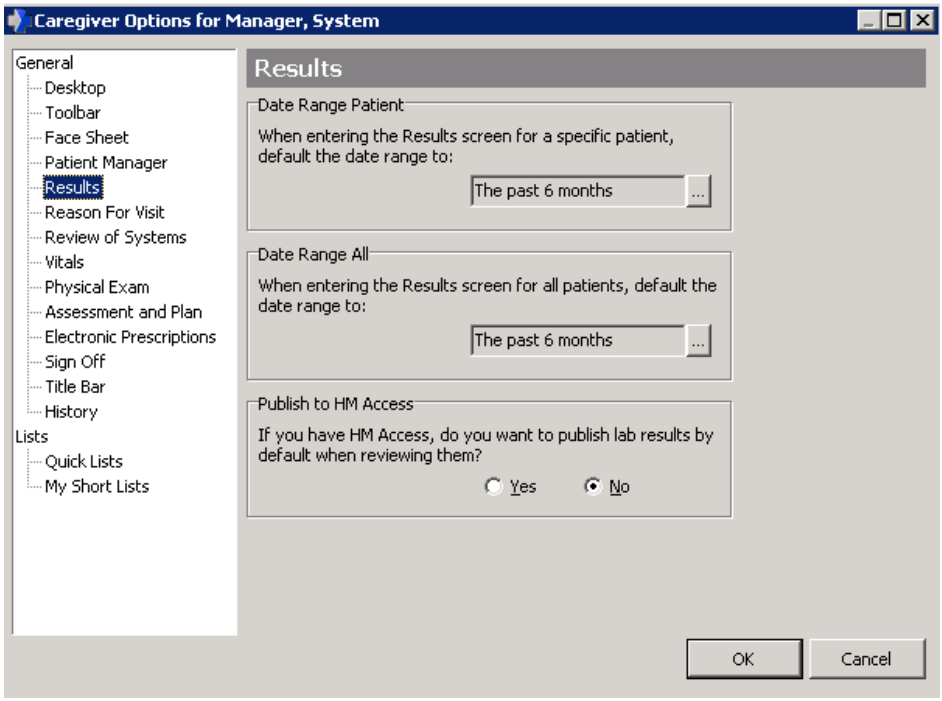
   - Deselect check boxes preceding items that you do **not** want to include in the *Patient Manager* view.
   - Position each item in the order you want to view it by highlighting the item and clicking the arrows to move it up or down in the list, or from one side to the other.

4. Click **OK** to exit ***or*** select another item in the left pane to set more defaults.

NOTE: Click **Reset Settings** to return the view to the original default settings (all selected, two columns).

To set results defaults

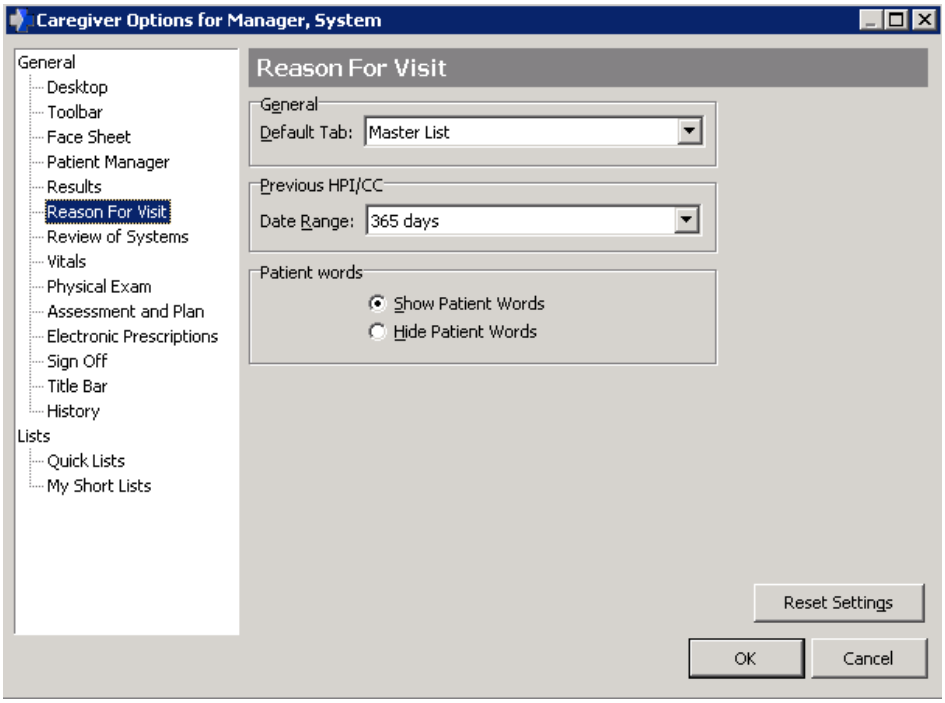
1. From the HealthMatics EMR menu bar, select **Options > Edit Options > Results**.



2. **Date range patient** - Click search to select default date range for viewing lab results for one specific patient.
3. **Date range all** - Click search to select default date range for viewing lab results for all patients.
4. **Publish to HM Access** - **IF** you bought and installed HealthMatics Access, select option for publishing reviewed results by default (**Yes**) or (**No**).
   If you select *Yes*, *Published* column sets to *Yes* by default when entering Lab Review screen (provided the practice has HealthMatics Access).
5. Click **OK** to exit ***or*** select another option in the left pane.

To set reason for visit defaults

1. From the HealthMatics EMR menu bar, select **Options > Edit Options > Reason for Visit**.



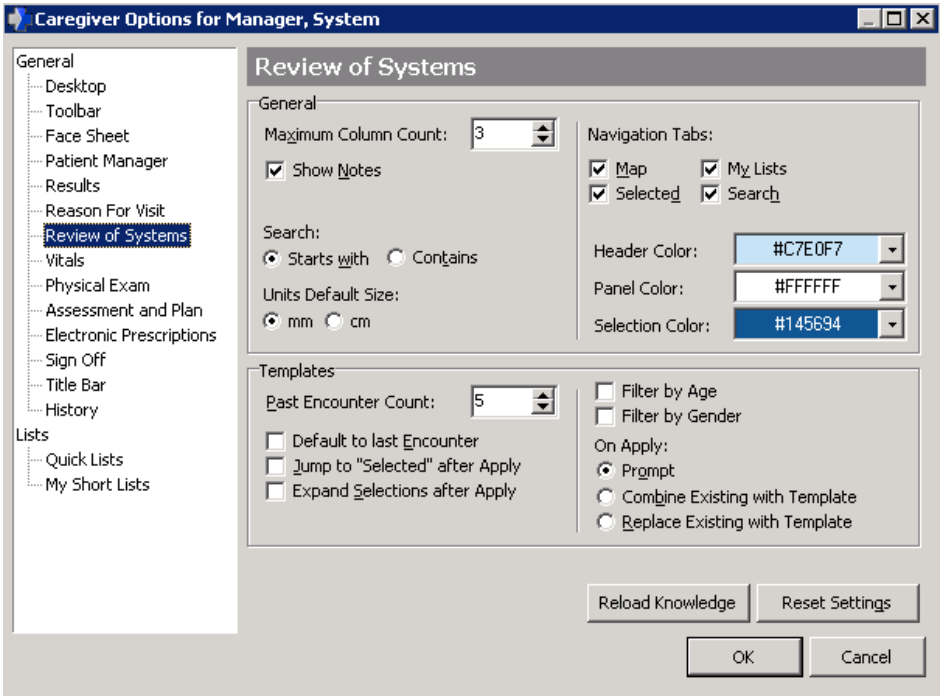
2. At *General*, click down-arrow to select the *Default Tab* that you want displayed when you open Reason for Visit: *Previous Complaints, My Short Lists, Short Lists, Master List*, or *Free Text.*
3. At *Previous HPI/CC*, click down-arrow to select the *Date Range* to constrain the amount of previous HPI/CC that you want to display on *Previous Complaints* tab. Choices extend from 30 days to 365 days.
4. At *Patient words*, click appropriate radio button to determine whether patient words should be shown or hidden.
5. Click **OK** to exit ***or*** select another item in the left pane to set additional defaults.

NOTE: Click **Reset Settings** to set all defaults in this view back to their original default settings.

To set review of systems and physical exam defaults

NOTE: The Review of Systems and Physical Exam options are identical.

1. From the HealthMatics EMR menu bar, select **Options > Edit Options > Review of Systems *or* Physical Exam**.



2. **General**

Screen Elements	Action
Maximum column count	Click the down-arrows to select the number of columns to display across the panel pane in Physical Exam (maximum 3 or 4).
Show notes	Select to display notes under the knowledge term in Review of Systems/Physical Exam.
Expand mapped images	Select to automatically open images mapped to items selected.
Search	Select a default (*Starts with* or *Contains*) for the *Search* feature in both the navigation pane and the Quick Search function: • **Starts with** - Select to restrict searches to only items that start with characters entered in the *Search* field. • **Contains** - Select to allow searches to show all items that contain the characters entered in the *Search* field.
Units default size	Select the default unit size (*mm* or *cm*).

Screen Elements	Action
Navigation tabs	Select or deselect boxes to show or hide *Map, Selected, My (PE) Lists*, and/or *Search* in your navigation pane (see ROS and PE Navigation on page 266).
Colors	Click the down-arrows and select colors for the *Header, Panel*, and *Selection* color.

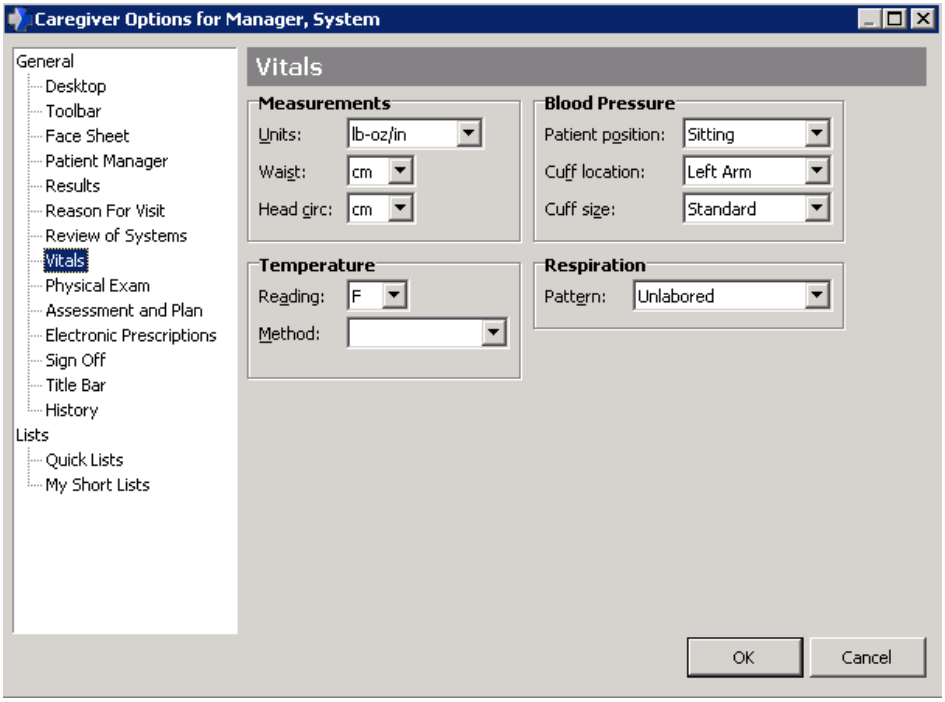
3. **Templates**

Screen Elements	Action
Past encounter count	Select the number of past encounters to list in the *Templates* drop-down list.
Default to last encounter	Select to default the template list to the patient's last encounter (if one exists).
Jump to selected after apply	Select to default the template to jump to the selected item after clicking **Apply**.
Expand selections after apply	Select to expand folders containing selections after clicking **Apply**.
Filter by age	Select to filter template items available by the age of the patient.
Filter by gender	Select to filter template items available by the gender of the patient.
On apply	When selecting a template and clicking **Apply**, set options to control how the template is applied to the current encounter: • **Prompt** - When you click **Apply**, a dialog box displays if previous data exist, which allows you to decide how to apply template data. • **Combine existing with template** - When you click **Apply**, template data are automatically combined with previously selected data. • **Replace existing with template** - When you click **Apply**, previously selected data are replaced with template data.
Reload knowledge	Use this button when customizing only.
Reset settings	Click to restore Review of Systems/Physical Exam caregiver options to the factory settings.

4. Click **OK** to exit or select another item in the left pane to set additional defaults.

To set vitals defaults

1. From the HealthMatics EMR menu bar, select **Options > Edit Options >Vitals**.



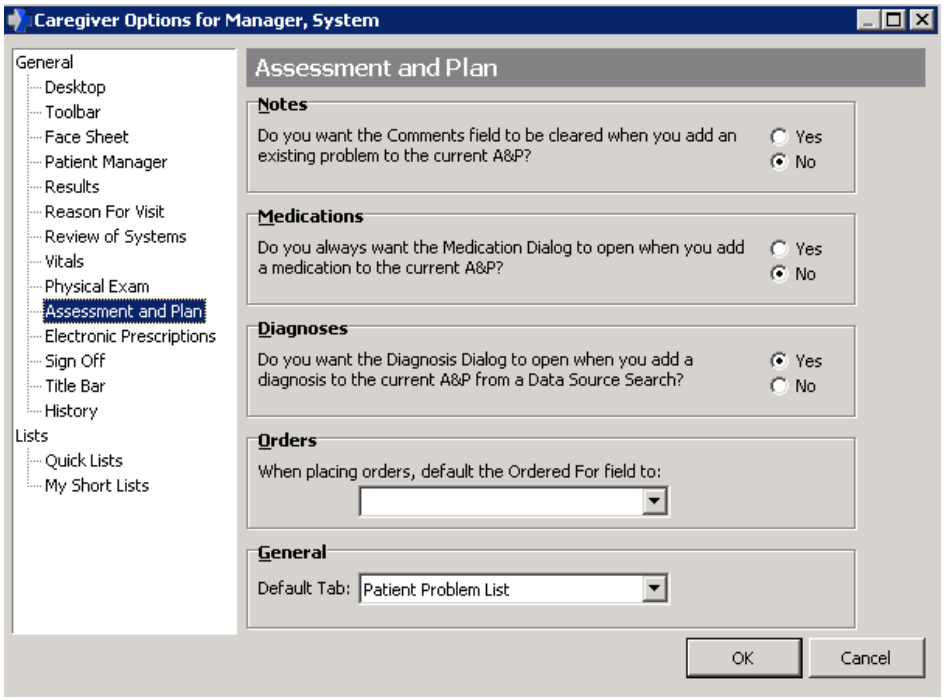
2. Set defaults as follow:

Screen Elements	Action
Default temperature settings	• **Units** - Select the usual notation for temperature units -- *Fahrenheit* or *Centigrade*. • **Method** - Select the usual method for taking patient temperatures: *Undefined, Oral, Tympanic, Rectal*, or *Axillary.*
Default respiration settings	**Pattern** - Click the down-arrow to select the respiration pattern
Default measurement units	Select usual notation for height and weight (*lb-oz/in, kg/cm*, or *lb-oz/ft-in*). **NOTE:** If you select *lb-oz/ft-in*, the *in.* field (in Vitals) changes to two fields -- *ft* and *in* -- needed to record the data in that format.
Default blood pressure settings	Select usual position, location, and size for blood pressure readings.
Default head circumference settings	Select the usual notation for measuring head circumference.
Default waist settings	Select the usual notation for measuring head circumference.

3. Click **OK** to exit ***or*** select other options in the left pane to set additional defaults.

To set assessment and plan defaults

1. From the HealthMatics EMR menu bar, select **Options > Edit Options > Assessment and Plan**.



2. **Notes** - Caretakers sometimes enter notes in the Comments section of the Assessment/Plan for patients with managed diseases.
   On succeeding visits, when pulling a problem from the *Patient Problem List*, you may prefer to see previous comments ***or*** you may prefer the *Comments* field to be blank, ready for new comments.

   - **Yes** - Comments (if any) from previous encounter are erased and the *Comments* field is blank, ready for new comments.
   - **No** - Comments (if any) about the existing problem display, and you can add the date and new comments at the end.

3. **Medications** - When selecting medications In *Assessment/Plan*:

   - **Yes** - Medication dialog displays automatically for entering medication details when adding a medication to the current encounter from either a *Data Source* or *Short List*.

     NOTE: Even if **Yes** is selected, the Medication dialog will **not** open automatically if you select a protocol. In this case, you will need to double-click or click **Edit** to enter medication details.

   - **No** - Double-click the medication ***or*** select it and click **Edit** after adding it to the current encounter to enter medication details.

4. **Diagnoses** - When selecting diagnoses from a *Data Source* search in *Assessment/Plan*:

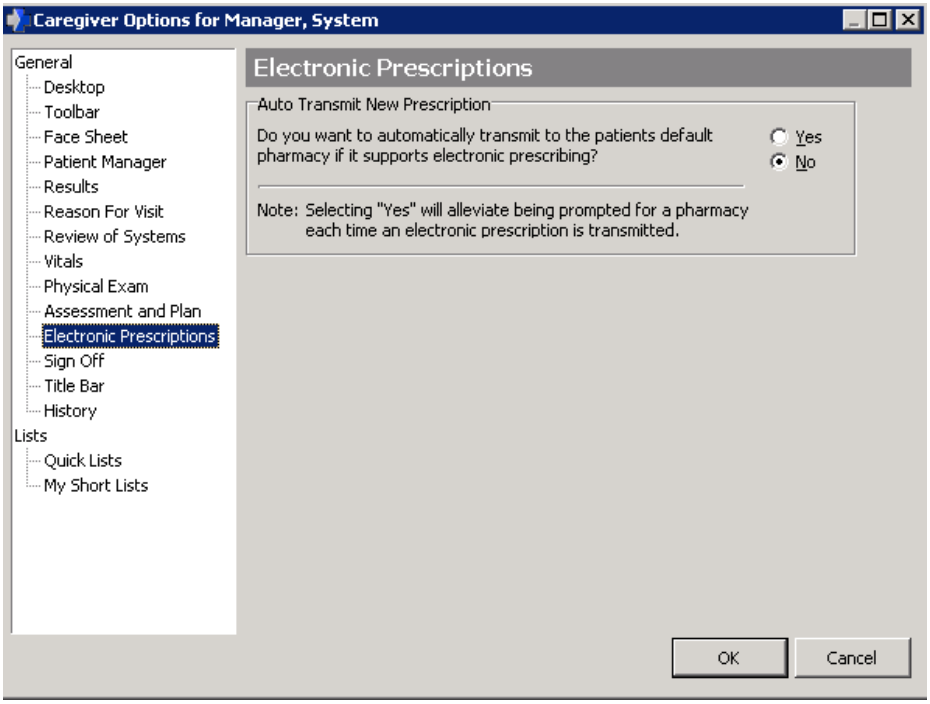
   - **Yes** - Problem dialog opens automatically for entering details

- **No** - Double-click the diagnosis ***or*** select it and click **Edit** after adding it to the current encounter to enter medication details.

5. **Orders** - Click the down-arrow to select the caregiver you want to default in the *Ordered For* field: *Appointment Caregiver, Preferred Caregiver*, blank (the default), and a list of grantors so that you can select an individual caregiver.
6. **General** - Click the down-arrow to select the *Assessment/Plan* tab you want to display by default: *Patient Problem List, Patient Medications, My Short Lists, Short Lists, Search*, or *Free Text*.
7. Click **OK** to exit ***or*** select other items in the left pane to set additional defaults.

To set electronic prescription defaults

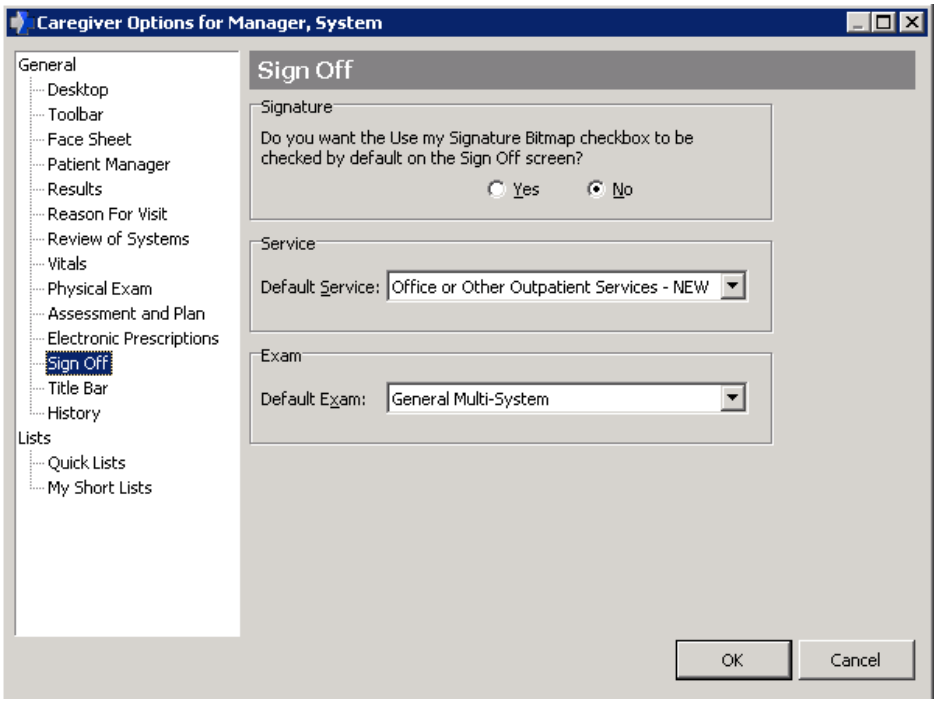
1. From the HealthMatics EMR menu bar, select **Options > Edit Options > Electronic Presriptions**.



2. At *Auto Transmit New Prescription*, select one of the following:
   - **Yes** - Automatically transmits to the patient's default pharmacy if it supports electronic prescribing, thus avoiding being prompted for a pharmacy each time an electronic prescription is transmitted.
   - **No** - Prompts you to select a pharmacy.
3. Click **OK** to exit ***or*** select other items in the left pane to set additional defaults.

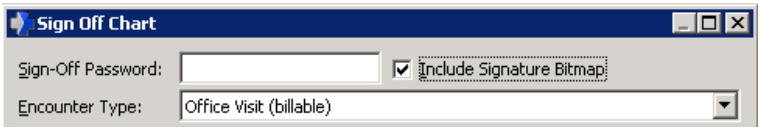
To set sign off defaults

1. From the HealthMatics EMR menu bar, select **Options > Edit Options > Sign Off**.



2. **Signature**

   - **Yes** - Automatically selects *Include Signature Bitmap* in Sign Off Chart, and appends your electronic signature to every H&P Report when you sign off.



   - **No** - Leaves *Include Signature Bitmap* deselected. The caregiver's signature line does **not** display on the H&P Report unless the caregiver manually checks the box.

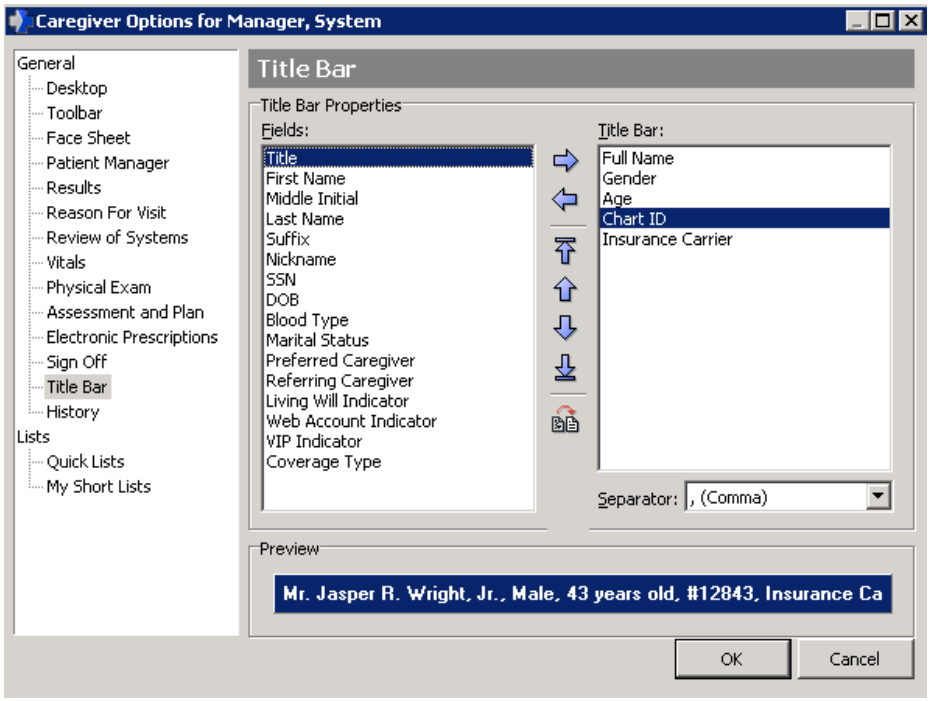
3. **Service** - Click the down-arrow to select most common service to default on E/M Calculator.

4. **Exam** - Click the down-arrow to select the most common exam to default on E/M Calculator.

5. Click **OK** to exit ***or*** select other options in the left pane to select additional defaults.

To customize the title bar

1. From the HealthMatics EMR menu bar, select **Options > Edit Options > Title Bar**.



- **Fields** - Lists items that can be selected for title bar, including *Separator* (punctuation marks and/or spaces).
- **Title bar** - Lists items selected for customized title bar.
- **Separator** - Clicking down arrow displays list of punctuation that can be used to separate items selected in title bar display.
- **Preview** - Displays title bar as it reflects selected fields.

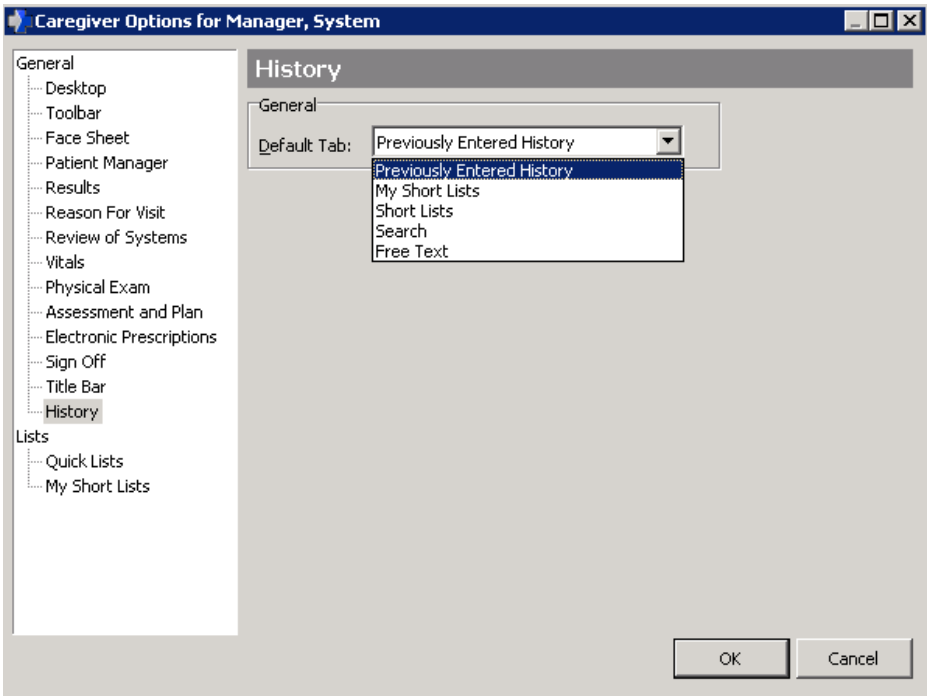
2. In *Fields* list, double-click or select items and click icons to move and sort them in *Title Bar* list.

Icon	Description
	Click to add item to title bar (or double-click the item in *Fields*)
	Click to remove item from title bar (or double-click the item)
	Move item to the top of the title bar list
	Move item up one in the title bar list (and to the left in the title bar)
	Move item down one in the title bar list (and to the right in the title bar)
	Move item to bottom of the title bar list
	Refresh default title bar data

3. At *Separator*, click the down-arrow and select the separator that you want between each item on title bar.
4. At *Preview*, review items and *Separator* selected for customized title bar and make changes if desired.
5. Click **OK** to save the selections and exit ***or*** select other items to set additional defaults.

To set history defaults

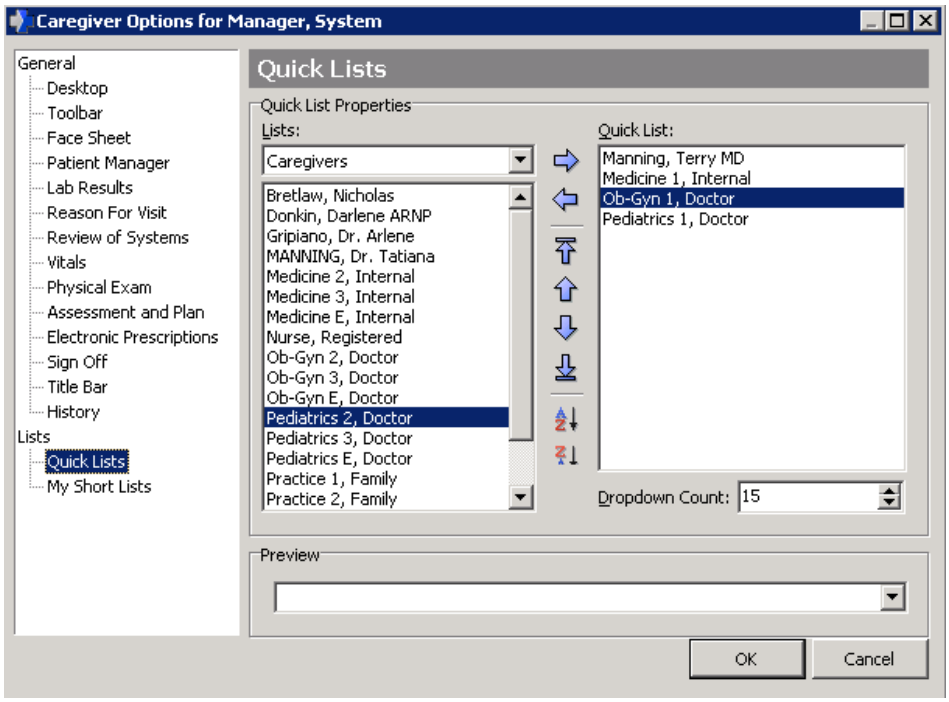
1. From the HealthMatics EMR menu bar, select **Options > Edit Options > History**.



2. Click the **Default Tab** down-arrow to select the tab that you want to default to open when you click (History) on the toolbar: *Previously Entered History, My Short Lists, Short Lists, Search*, or *Free Text*.

To customize quick lists

1. From the HealthMatics EMR menu bar, select **Options > Edit Options > Quick Lists**



2. From left pane under *Lists*, select **Quick Lists**.
3. At *Lists*, click down-arrow to select a list type.
4. In list of items that display, double-click items or select them and click to move them to *Quick List*.

   NOTE: To remove an item from *Quick List*, double-click it ***or*** select it and click .
5. Continue selecting quick list items as needed.
6. Sort quick list using icons below:

Icon	Name	Action
	Move to Top	Click to move item to the top of the list.
	Move Up	Click to move item up one.
	Move Down	Click to move item down one.
	Move to Bottom	Click to move item to the bottom of the list.
	Sort Ascending	Click to sort list in ascending order.
	Sort Descending	Click to sort list in descending order.

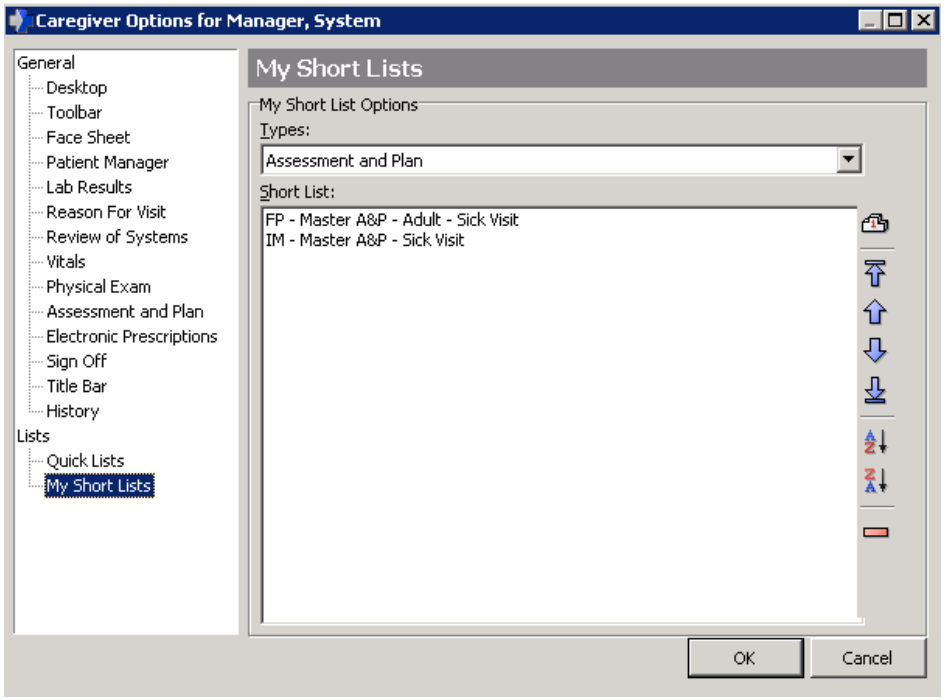
7. At *Dropdown Count*, limit number of items that display in drop-down list without scrolling by clicking spin arrows to select number between 15 and 50.

8. Click the **Preview** down-arrow to view the customized list, followed by dotted lines and the remaining items.
9. Click **OK** to save the selections and exit ***or*** select other items to set additional defaults.

To sort or delete my short lists

Using the **Clinical Customization Module**, each practice creates shorts lists to assist with documentation. In Reason for Visit, History, and Assessment/Plan, each caregiver can designate the short lists used most often as “My Short Lists.” In Caregiver Options, each caregiver can customize the order in which My Short Lists appear, or delete them.

1. From the HealthMatics EMR menu bar, select **Options > Edit Options > My Short Lists**.



2. Click the **Types** down-arrow and select the type of short lists to display in the box below.
3. In the *Short List* box, select items and click icons to rearrange the list.

Icon	Name	Action
	Make Default	Click to make the item the default
	Move to Top	Click to move the item to the top of the list
	Move Up	Click to move the item up one
	Move Down	Click to move the item down one
	Move to Bottom	Click to move the item to the bottom of the list

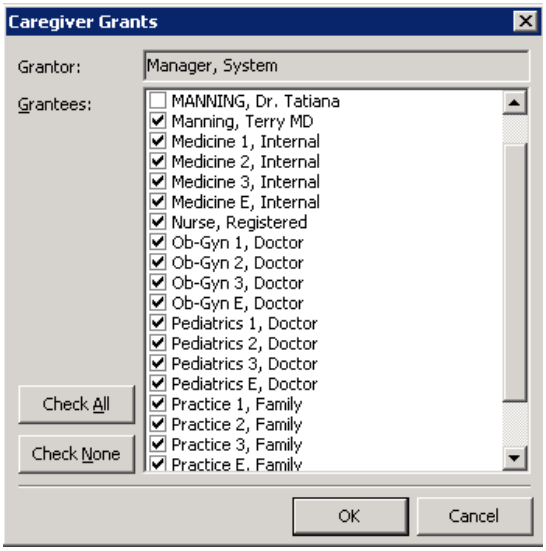
Icon	Name	Action
	Sort Ascending	Click to sort the items in ascending order
	Sort Descending	Click to sort the items in descending order
	Delete	Click to delete item from *My Short Lists*

4. Click **OK** to save changes and exit ***or*** select other items to set additional defaults.

Editing grants

You can grant permission for other caregivers in your practice to access your inbox, outbox, and worklog. This is particularly useful if another caregiver is going to cover for you in your absence. Caregivers with grants to your message can view any items other than *Action Items* marked *Private*.

1. On the HealthMatics EMR menu bar, select **Options > Edit Grants** to display Caregiver Grants.Do **one** of the following:



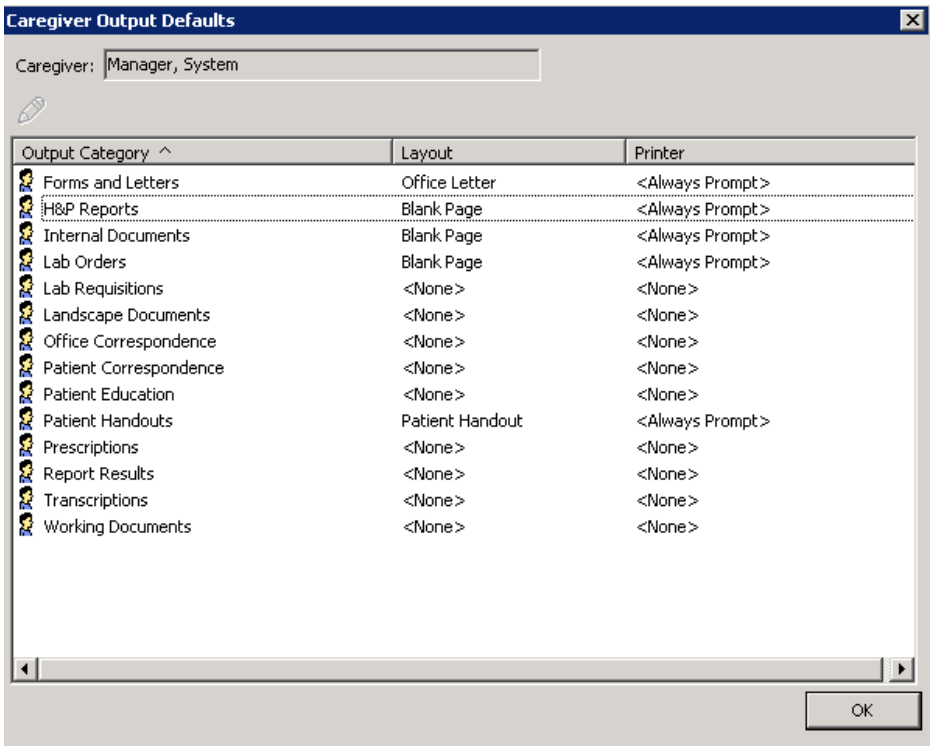
- Click **Check All** and then deselect individual caregivers, if needed ***or***
- Click **Check None** and then select individual caregivers, if needed.

2. Click **OK** to return to the desktop.

Editing output defaults

You can set caregiver preferences for default printers for each document type that you print.

1. From the HealthMatics EMR menu bar, select **Options > Edit Output Defaults.**



2. Highlight an *Output Category* and do one of the following to display Output Default Properties:
   - Press **F2** ***or***
   - Double-click it ***or***
   - Click (Edit Layout Default).
3. Click the **Layout** down-arrow to select the appropriate layout for the output.
4. Click the **Printer** down-arrow to select a default printer ***or*** select **<Always Prompt>** if you want to be able to select the printer each time you print this document type.

   NOTE: If you select <*Always Prompt*> the *Printer* field remains blank.
5. Click **OK** to save the default printer for that layout.
6. Select another *Output Category* to set more printer defaults or click **OK** to exit.

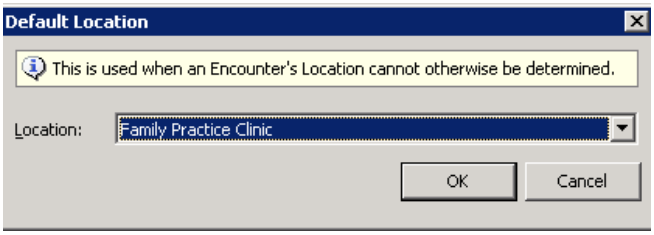
NOTES

- Any *Output Categories* without default printers assigned default to <*Always Prompt*>.
- Caregiver output defaults can also be set by clicking **My Output Defaults** on the toolbar of the **Administration Module**.

Editing default locations

The system uses the default location when an encounter is not associated with a scheduled appointment.

1. To set the default location, from the menu bar, select **Options > Edit Default Location**.



2. Click the **Location** down-arrow, select a location, and click **OK**.

Editing auto replace text

In HealthMatics EMR, you can set up automatic corrections for commonly mis-typed text, as well as create standard statements that auto-expand upon typing the first few letters of the statement in all *Note, Comment,* and free text fields.

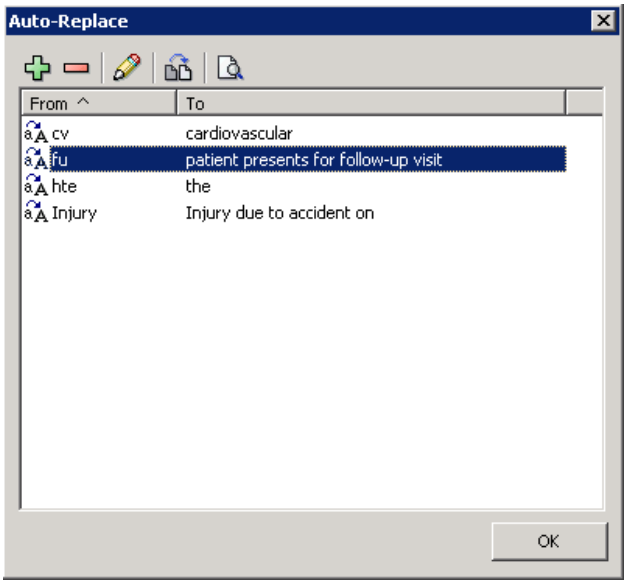
Auto-correct example: Ask the system to automatically correct “respitory” to “respiratory” or correct “hte” to “the.”

Auto-expand example: Ask the system to automatically expand “cv” to “cardiovascular,” or “Injury,” to “Injury due to accident on ” or “fu” to “Patient presents for follow-up visit for “

Both Auto-correct and Auto-expand are linked to the user’s login name, so they are available at each workstation.

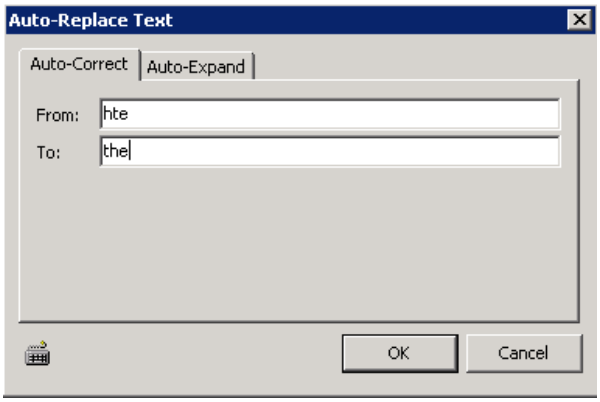
1. To access Auto-Replace, do one of the following:
   - From the menu bar, select **Options > Edit Auto-Replace Text *or***

- From any text or comment box that displays the icon, click (Auto-Replace).



2. **Add** - To add new items, press **Insert** on your keypad ***or*** click (Add)

   - **Auto-correct** - To correct common typing errors automatically, select the **Auto-Correct** tab.

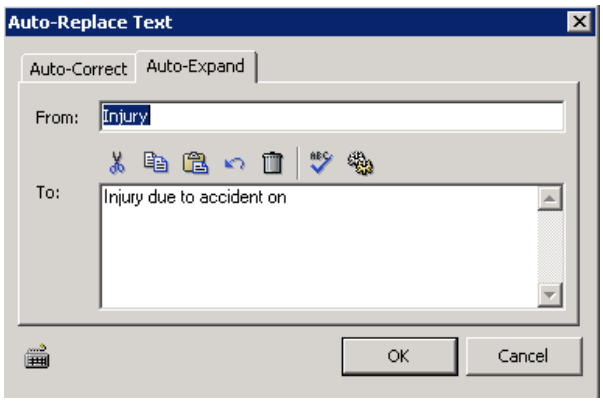


   > At *From*, enter the word as you commonly mis-type it.

   > At *To*, enter the word spelled correctly (up to 200 characters).

   > Click **OK** to return to Auto-Replace.

- **Auto-expand** - To add auto-expanding items, in Auto-Replace, click (Add) and select the **Auto-Expand** tab.



  > At *From*, type the short text that you want to expand.

  > At *To*, type the expanded text up to 2,000 characters.

  > Click **OK** to return to Auto-Replace.

  The replacement items that you entered are listed. Whenever you type the text items in the *From* field, the system automatically changes them to the text items in the *To* field.

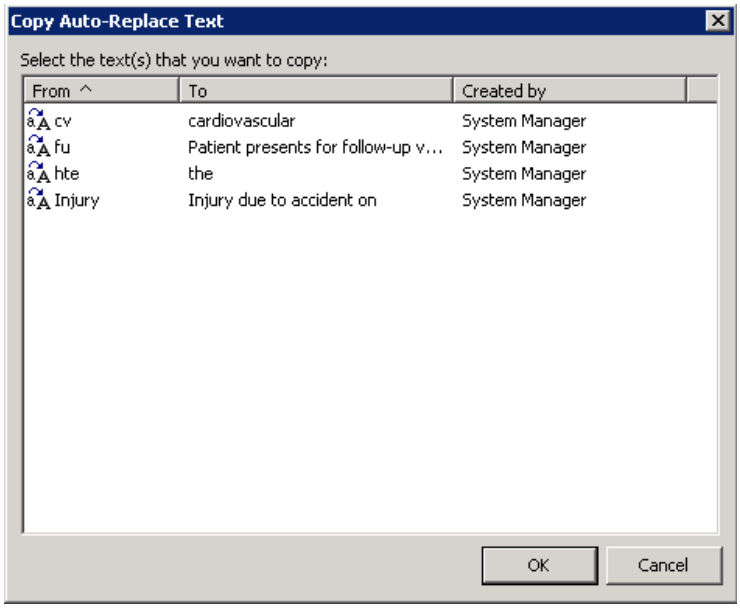
3. **Edit** - To edit Auto-Replace items, in the Auto-Replace dialog box, select an item and press **F2** ***or*** click (Edit) to display Auto-Replace Text.

   - At *To*, edit the entry as needed.
   - Click **OK** to return to Auto-Replace.

   NOTE: The SQL database is **not** case-sensitive, so it sees “HL7” and “HI7” as the same. This helps prevent duplication.

4. **Delete** - To delete Auto-Replace items, in Auto-Replace, select an item and press **Delete** on your key pad or click (Delete) and **Yes** to confirm.

5. **Copy** - To copy auto-replace entries from other users, in Auto-Replace, click (Copy) to display other caregivers' entries in Copy Auto-Replace Text.



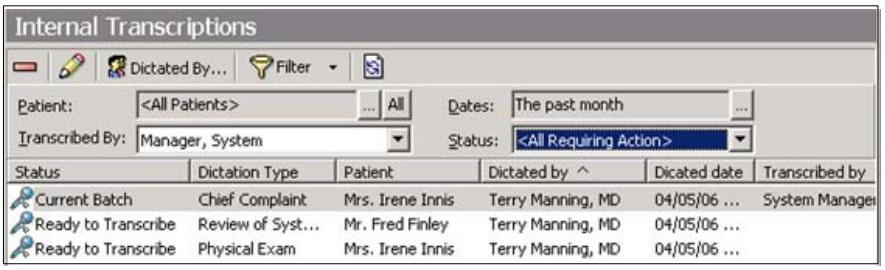
   > Select the entry you want to copy and click **OK** to display the entry in Auto-Replace.

6. Click **OK** to close Auto-Replace.

Internal Transcription

Use the **Input Manager** to transcribe **Voice** notes recorded throughout the contact screens in HealthMatics EMR.

1. From the HealthMatics EMR menu bar, select **Launch > Input Manager**.
2. In the left pane, select **Internal Transcriptions**.



You can click secondary toolbar icons to do any of the following:

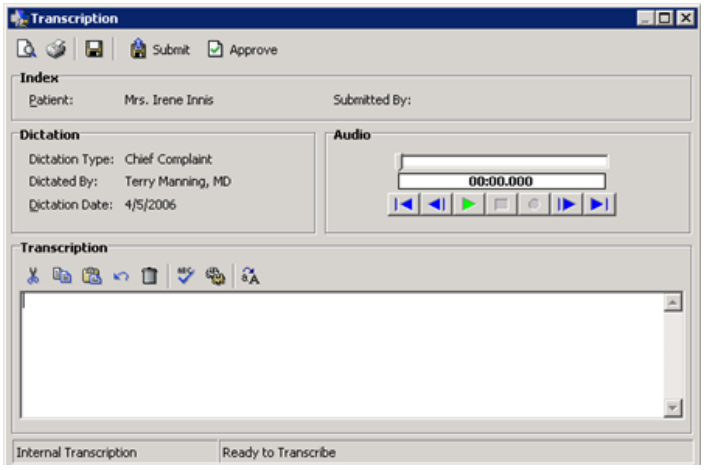
Icon	Name	Action
	Delete (**Delete**)	<Dictation cannot be deleted.>
	Edit (**F2**)	Edit selected item.
	Dictated by	Filter the list by caregiver.
Filter	Filter	Select a quick filters (see Quick Filters on page 98).
	Refresh list (**F5**)	Pulls into the view any data that changed recently.

3. Use any of the following filters to locate dictation:
   - Click **Dictated By** to view dictation for a specific caregiver.
   - Click (Filter) to use a quick filter to search for dictation, based on pre-set filters (see Quick Filters on page 98).
   - At *Patient*, click ... to search for a specific patient; otherwise, click **All**.
   - To view dictation sent to individual transcriptionist, click the **Transcribed By** down-arrow and select the transcriptionist; otherwise, select **<All Grantors>**.
   - Click the **Dates** search button to select a date range for the dictation.
   - Click the **Status** down-arrow and select a status.
4. Click any column heading to sort items.

Heading	Description
Status	Statuses include the following: *<All Requiring Action>, <All Statuses>, Current Batch, Ready to Transcribe, Submitted, Rejected, Approved*, or *Others*.
Dictation Type	Name of contact screen on which voice note was dictated

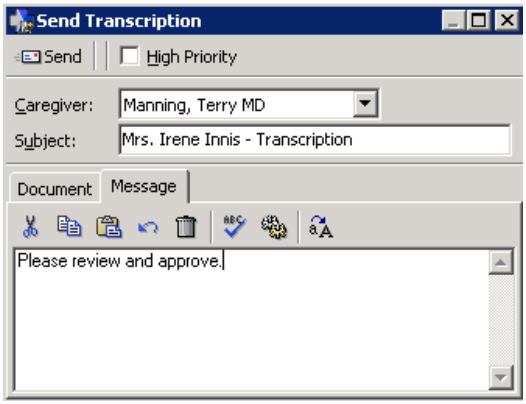
Heading	Description
Patient	Patient name
Dictated by	Dictating caregiver
Dictated date	Date dictated
Transcribed by	Transcriptionist

5. Select an item and do one of the following to open it:
   - Press **F2** on your keyboard ***or***
   - Double-click ***or***
   - Click (Edit Selected Item) ***or***
   - Right-click and select **Edit**.



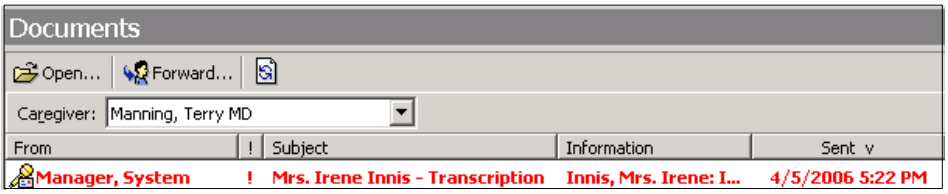
6. Click (Play) to listen to the voice note as you enter the transcription text in the large free-text field at the bottom of the dialog box.
7. Click **Audio** buttons as needed to move to the beginning of a dictation, rewind, play, stop, pause, fast-forward, and to move to the end of the dictation as needed.
8. When you have completed the transcription, click (Save).
   The *Status* in the *Internal Transcription* view changes to *Current Batch*.
9. Click to preview the transcription or click from the Transcription or Preview dialog boxes to print it for review.

10. Click **Submit** ( ) to send the transcription to the dictating caregiver for approval.



11. Verify the *Caregiver* and *Subject*, enter a text *Message* to the caregiver, select **High Priority**, if appropriate, and click **Send**.

The transcription goes immediately to the *Documents* Inbox of the designated Caregiver and increases the Documents status bar number by 1.

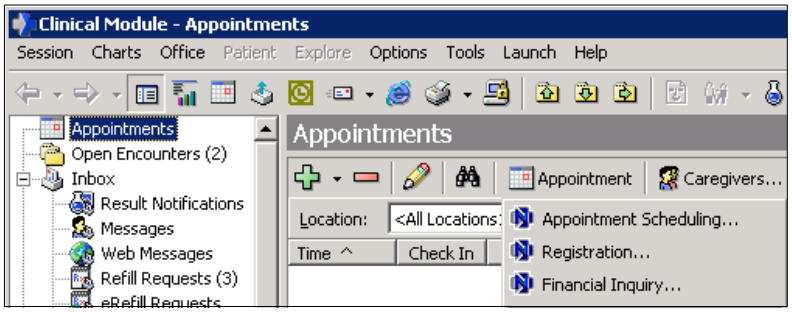


For instructions for approving transcription, see Approving or rejecting documents on page 71.

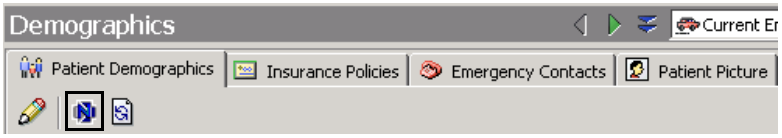
Practice Management System Interface

You can access your Ntierprise Practice Management System without leaving the Clinical Module of HealthMatics EMR. For instructions for using the Ntierprise screens that you access, refer to it online help:

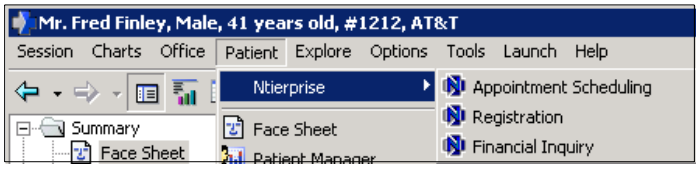
- **Appointments** - On the *Appointments* toolbar, click (Appointment) for a drop-down menu of Ntierprise options.



- **Demographics** - On the *Demographics* secondary toolbar, click (Ntierprise Registration).



- **Patient** - With a patient chart pulled, on the application menu bar, select **Patient > Ntierprise** for a drop-down menu of Ntierprise options.



2. Chart Functions

Electronic patient charts are similar to paper charts. They include all of the following:

- Patient Charts on page 139
- Demographics on page 162
- Face Sheets on page 145
- Patient Manager on page 173
- Lab Results on page 175
- Procedure Results on page 188
- Additional Results on page 195
- Report Results on page 198
- Result Summaries on page 199
- Flow Sheets on page 206
- Chart Attachments on page 208
- Reminders on page 211

Patient Charts

HealthMatics EMR stores patient information in patient charts, similar to paper charts. You can pull charts, enter information in them, send charts to other caregivers, and file charts. You can also print information from charts.

Pulling charts

IMPORTANT!

You can pull charts from multiple locations within HealthMatics EMR. However, to **ensure accurate billing** for a visit, if you use HealthMatics EMR with a practice management system (PMS), **always** pull patient charts from either *Appointments* ( ) or Received Charts ( ) in the left pane of the desktop or the status bar.

To pull patient charts for billing

From appointments

1. From the left pane of the HealthMatics EMR desktop, or the office menu, click **Appointments**.
2. From the right pane, double-click the appointment to open the chart to the patient face sheet.

From received charts

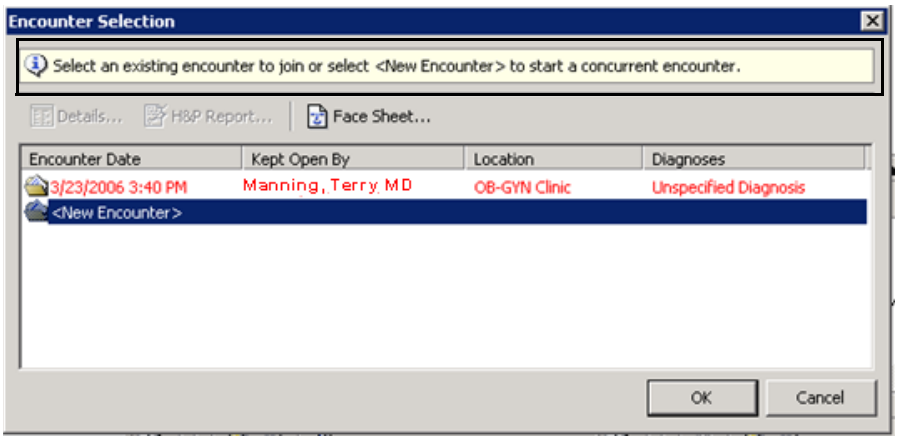
1. During patient visits, from the status bar (or inbox on the desktop), click 1 (Received Charts).
2. From the right pane, double-click the item to view the Chart Message attached to the chart.

3. Click **Pull Chart**, then click **Yes** to delete the message once the chart is pulled.

To pull charts for concurrent encounters

Depending on administration module settings selected by your practice, more than one encounter at a time can be open for a patient chart. You can select an encounter to join.

1. From the HealthMatics EMR Appointment screen, double-click the patient to pull the chart. If an encounter is in progress, the following message displays.



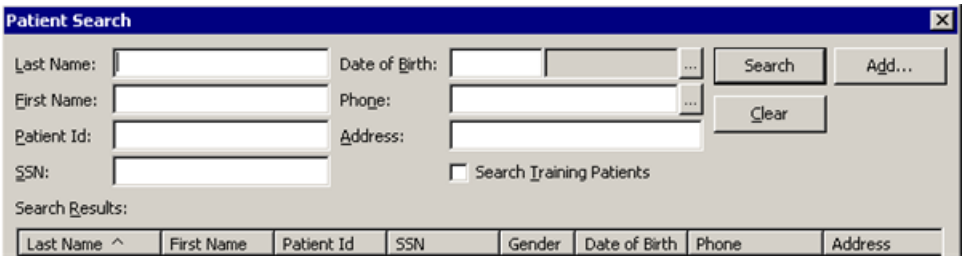
2. Select an existing encounter to join or click **<New Encounter>** to open a new encounter that will be open at the same time as the existing encounter.

3. Click **OK**.

To pull patient charts for non-billable contact

You can pull charts for non-billable purposes such as reviewing previous encounter information, entering lab or procedure test results, or entering demographic information.

1. From the HealthMatics EMR toolbar, click (Pull Chart).



NOTE: If your practice has a practice management system, **Add** may not appear on your Patient Search screen. In this case, enter new patients into your PMS or see your system administrator to change site settings to *Allow Demographics Entry*.

2. Enter data in the fields, then click **Search**.

NOTES
*** SSN** - The Social Security number field automatically adds the hyphens once the ninth digit is typed (999999999 becomes 999-99-9999.)

* **Date of birth** - To enter a date of birth, type the date using the format: xx/xx/xxxx (month/date/year) ***or*** click the search ... button to display a quick entry window. For instructions, see Entering dates on page 10.

* **Phone** - Enter a telephone number. For instructions see Entering phone numbers on page 10. Click ... to display a quick entry box.

* **Add** - The button displays in Patient Search **only** if the site setting for *Allow Demographics Entry* is checked in the **Administration Module**. If not checked, **Add** does not appear, and all patients must be entered in the Practice Management System and pulled into the EMR across the interface.

3. If the patient name does not display in the list, enter other identifying information in the search fields and click **Search** ***or*** press **Enter**.

NOTES
*** Search criteria** - If you enter information in more than one field, HealthMatics EMR searches for the chart that meets **all** of the criteria.

* **Search results** - HealthMatics EMR displays a default list of patients whose charts were pulled by caregivers within the last (15) days. Your system administrator can change the number of days in the Administration Module.

* **Inactive/deceased patients**
- Inactive patients display in gray font.
- Deceased patients display in strikeout font.
- Inactive deceased patients display in gray strikeout font.

* **Sort** - Click any column heading to sort the list by that item.

4. To select a patient, double-click the patient ***or*** select the patient from the list and click **OK**.

To review open encounters

1. From the HealthMatics EMR desktop status bar or left pane, click (Review Open Encounters).

2. To open a patient chart, double-click the patient name ***or*** select it and, on the secondary toolbar, click **Open**.

To enter reason kept open

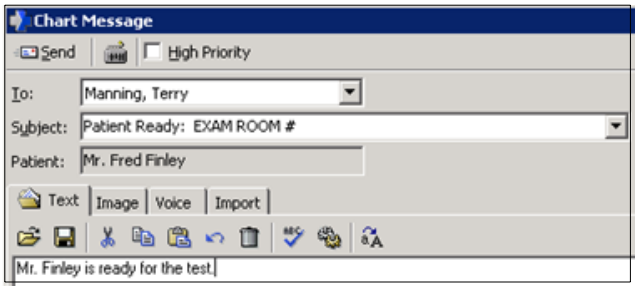
When you keep a chart open on your desktop rather than signing off and/or filing it, enter a Reason Kept Open so you (and other caregivers) know why it remains open.

1. Open a patient chart, and from the toolbar, click (H&P Report).

2. Click the **Reason Kept Open** down-arrow and select a reason.

Sending charts to other caregivers

1. With a chart open in HealthMatics EMR, from the toolbar, click (Send Chart).



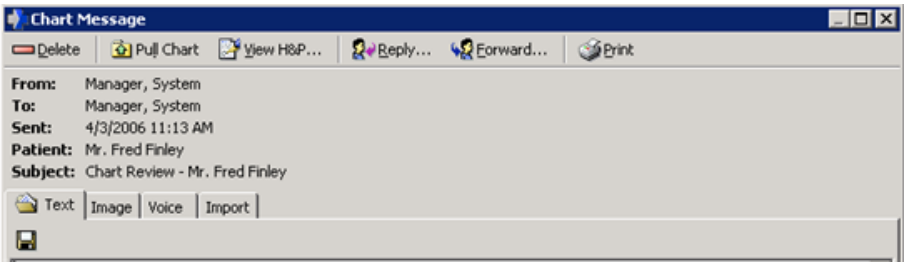
2. Select **High Priority**, if desired, to display the item in red on the caregiver desktop.
3. Click the **To** down-arrow to select the caregiver to receive the chart.
4. At *Subject*, type a subject ***or*** click the down-arrow to select one.
5. If desired, select a tab (*Text, Image, Voice*, or *Import*) and enter information to accompany the chart.

   NOTE: Information entered on tabs is **not** saved to the patient chart.
6. Click **Send**.

NOTE: When you send a chart to another caregiver, the chart message displays in the *Received Charts* view of the recipient inbox, and in your outbox until the chart is pulled. See Reviewing received charts on page 143.

Reviewing received charts

1. From the status bar ***or*** left pane of the HealthMatics EMR desktop, click (Review Received Charts).
2. Double-click a name on the list to view the message attached to the chart.



3. To review the chart, click **Pull Chart** and **Yes** to remove the message from your inbox.

NOTE: Received chart messages are removed according to these conditions.

- If the sender did not enter any contact data (Reason for Visit through H&P screens), you can remove the message without pulling the chart.
- If the sender did enter data in any of the contact windows, you must pull the chart or have the chart on your desktop before removing the message.

The message can also be removed by forwarding it to another caregiver who is authorized to pull that patient chart and remove the message.

Filing charts

You can file charts from either the toolbar or from the status bar.

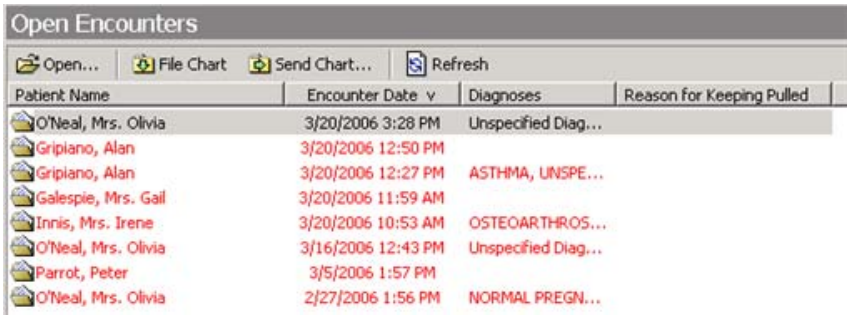
To file an open chart from the toolbar

To file the chart for a patient whose name displays on the title bar in HealthMatics EMR, click (File Charts) on the toolbar or press **F4**.

NOTE: If a chart needs to be signed off by the caregiver, the H&P report displays for signoff.

To file charts from the desktop or status bar

1. From the status bar ***or*** left pane of the desktop, click (Review Open Encounters).


Open Encounters
Open...
File Chart
Send Chart...
Refresh
Patient Name
Encounter Date
Diagnoses
Reason for Keeping Pulled
O'Neal, Mrs. Olivia 3/20/2006 3:28 PM Unspecified Diag...
Gripiano, Alan 3/20/2006 12:50 PM
Gripiano, Alan 3/20/2006 12:27 PM ASTHMA, UNSPE...
Galespie, Mrs. Gail 3/20/2006 11:59 AM
Innis, Mrs. Irene 3/20/2006 10:53 AM OSTEOARTHROS...
O'Neal, Mrs. Olivia 3/16/2006 12:43 PM Unspecified Diag...
Parrot, Peter 3/5/2006 1:57 PM
O'Neal, Mrs. Olivia 2/27/2006 1:56 PM NORMAL PREGN...

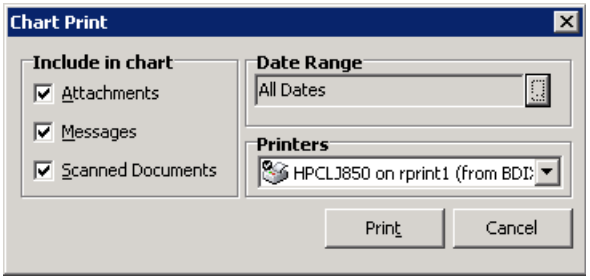
2. Highlight the patient name, and from the secondary toolbar, click **File Chart** ***or*** right-click the name and select **File Chart**.

NOTES

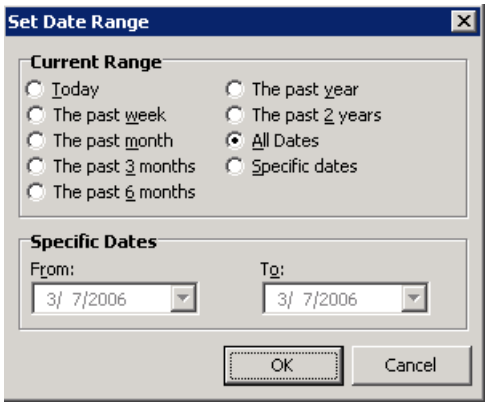
- If a chart needs to be signed off by the caregiver, the H&P report displays for signoff.
- You can file charts without signing off on them when any of the following are true:
  - > You opened them for review only.
  - > You made changes from the face sheet view only.
  - > You entered data in Demographics, Lab or Procedure Results, Reminders, or Chart Attachments only.
- You **must** sign off on a chart before filing if you entered information in any of the contact windows: Reason for Visit, Vitals, History, Review of Systems, Physical Exam, Assessment & Plan or on a Flow Sheet.
- If you attempt to file a chart requiring sign off, the H&P report displays so that you can sign off on the chart. Signing off from the H&P ends the encounter and automatically files the chart.

Printing entire charts

1. Open a patient chart to the face sheet ( ).
2. On the toolbar, click **> Print Entire Chart**.



3. *At Include in chart*, select (or deselect) the items you want to print.
4. At *Date Range*, click the search button ( ).



5. In *Current Range*, select the period of time you want to include for the documents.

   NOTE: If you select *Specific dates*, enter the dates in the *Specific Dates* fields below.

6. Click **OK**.

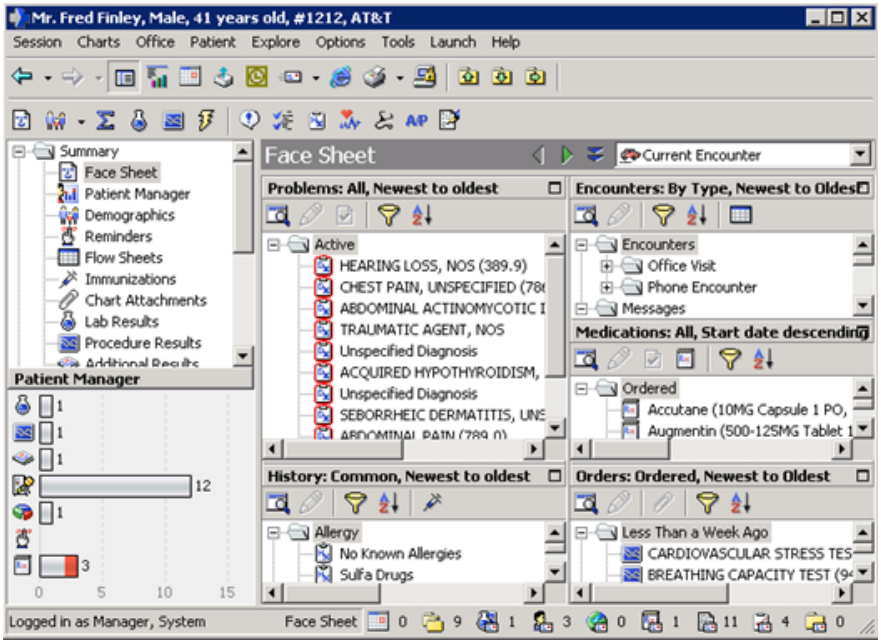
7. Click the **Printers** drop-down arrow to select a printer, then click **Print**.

Face Sheets

The face sheet view provides a summary of each patient chart. Each of its five panes displays a list of items, including *Problems, History, Encounters, Medications*, and *Orders*.

1. To access a patient face sheet in HealthMatics EMR, do **one** of the following:

   - Pull a patient chart (see Pulling charts on page 139) ***or***
   - If you have a chart open, from the left pane ***or*** the toolbar, click (Face Sheet).



2. Each face sheet pane has its own toolbar. Click any icon to sort and change the view.

Icon	Name	Action
	View Revision History	Click to open and enlarge the Explorer window to view revisions/ history.
	Edit Problem	Click to edit a selected problem, history, encounter, or medication.
	Inactivate Problem	Click to inactivate a selected problem or medication.

Icon	Name	Action
	Toggle Filter	Click to change the way items are grouped within a pane. **Example:** *By Type* or *By Date* in the Encounter pane.
	Toggle sort	Click to change the way items sort within a pane. **Example:** Oldest to Newest or Newest to Oldest.
	View Flowsheets	In the *Encounters* pane, click to view patient flow sheets.
	Immunizations	Click to access Immunization Record and edit Immunizations.
	Attachments	Click to access attachments.
	Refill Medications	In the *Medications* pane, select the medication to refill.
	View Interactions	In the *Medications* pane, click to view interactions.
	Maximize	Click to maximize the selected pane.
	Restore	Click to restore the maximized pane view and display all five panes.

NOTE: You can do all the following from face sheets:

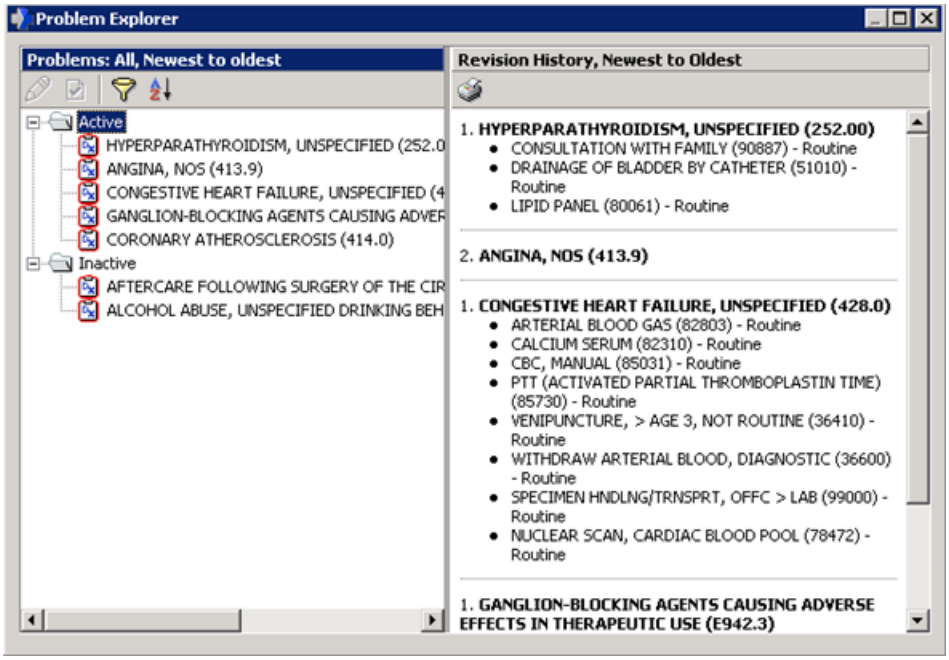
- View the revision history of any item.
- Inactivate or reactivate patient problems or medications.
- Review H&P reports from previous encounters in chronological order.
- Update patient history, medications, and problem information.
- Associate patient messages, refill requests, or chart attachments with specific encounters.
- View and email laboratory and procedure test results.

You can view some information (problems, history, medications) currently being entered in an encounter (not yet saved to the database).

Viewing and revising problems from face sheets

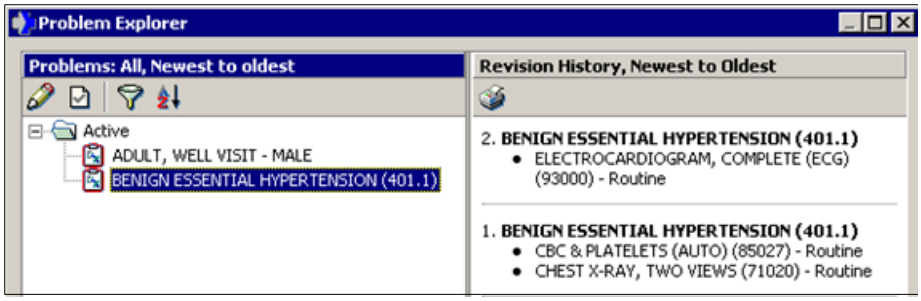
To view problems

1. Open a patient chart, and in the *Problems* pane, click (View Revision History) to display Problem Explorer.


Problem Explorer
Problems: All, Newest to oldest
Active
HYPERPARATHYROIDISM, UNSPECIFIED (252.0
ANGINA, NOS (413.9)
CONGESTIVE HEART FAILURE, UNSPECIFIED (4
GANGLION-BLOCKING AGENTS CAUSING ADVER
CORONARY ATHEROSCLEROSIS (414.0)
Inactive
AFTERCARE FOLLOWING SURGERY OF THE CIR
ALCOHOL ABUSE, UNSPECIFIED DRINKING BEH
Revision History, Newest to Oldest
1. HYPERPARATHYROIDISM, UNSPECIFIED (252.00)
CONSULTATION WITH FAMILY (90887) - Routine
DRAINAGE OF BLADDER BY CATHETER (51010) - Routine
LIPID PANEL (80061) - Routine
2. ANGINA, NOS (413.9)
1. CONGESTIVE HEART FAILURE, UNSPECIFIED (428.0)
ARTERIAL BLOOD GAS (82803) - Routine
CALCIUM SERUM (82310) - Routine
CBC, MANUAL (85031) - Routine
PTT (ACTIVATED PARTIAL THROMBOPLASTIN TIME) (85730) - Routine
VENIPUNCTURE, > AGE 3, NOT ROUTINE (36410) - Routine
WITHDRAW ARTERIAL BLOOD, DIAGNOSTIC (36600) - Routine
SPECIMEN HNDLNG/TRNSPRT, OFFC > LAB (99000) - Routine
NUCLEAR SCAN, CARDIAC BLOOD POOL (78472) - Routine
1. GANGLION-BLOCKING AGENTS CAUSING ADVERSE EFFECTS IN THERAPEUTIC USE (E942.3)

2. In the *Problems* pane on the left, do either of the following:

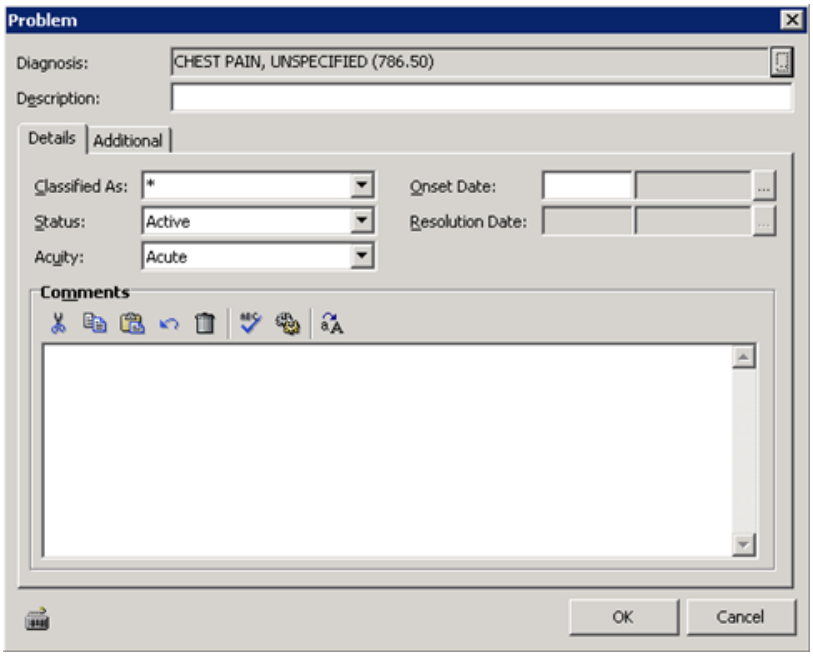
   - **Latest occurrence** - To see the latest occurrence of each patient problem in any category, highlight the folder (**Active, Inactive**, or **Resolved**) to display the most recent occurrence of each on the right.
   - **Single problem history** - To view all occurrences of a specific problem, highlight the problem to show all occurrences on the right with the most recent occurrence at the top.


Problem Explorer
Problems: All, Newest to oldest
Active
ADULT, WELL VISIT - MALE
BENIGN ESSENTIAL HYPERTENSION (401.1)
Revision History, Newest to Oldest
2. BENIGN ESSENTIAL HYPERTENSION (401.1)
ELECTROCARDIOGRAM, COMPLETE (ECG) (93000) - Routine
1. BENIGN ESSENTIAL HYPERTENSION (401.1)
CBC & PLATELETS (AUTO) (85027) - Routine
CHEST X-RAY, TWO VIEWS (71020) - Routine

NOTE: You can also double-click an item in the *Problem* pane on the face sheet to display its history in Problem Explorer.

To revise problem status

1. From the Problems pane of the face sheet, select the problem and click (Edit Problem).



2. For the *Details* tab, click down-arrows or enter information to revise any of the following:

Field	Description
Details tab	
Diagnosis	Displays the name and ICD-9 for the problem selected on the face sheet. Click the **Diagnosis** search button to edit the ICD-9 for the diagnosis (see To revise diagnoses from face sheets on page 150).
Description	Change the description for the problem if desired.
Classified As	Click the down-arrow to select a classification for the nature of the problem. **Examples:** *Principal, Established, Admitting,* and so forth.
Onset Date	Change the date on which the problem began. If necessary, enter the month, day, and year the problem began ***or*** click the calendar button to select the date when the problem began.
Status	Click the down-arrow to select *Active, Inactive, Resolved, Erroneous Entry,* or *Undefined*.

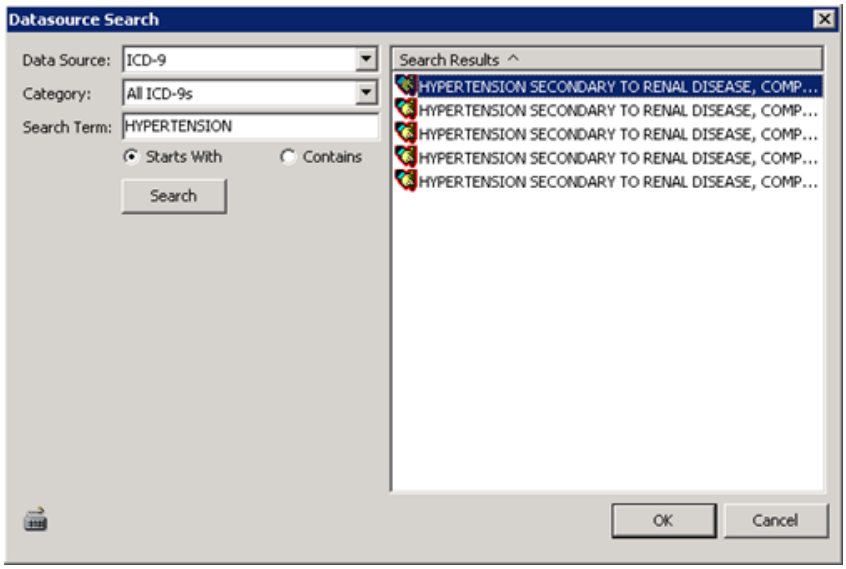
Field	Description
Resolution Date	Enter the date the problem resolved ***or*** click the ellipsis button … to enter the date. **NOTE:** This field appears only when you select *Resolved* in the *Status* field. Enter the month, day, and year.
Acuity	Describe the problem type: *Acute, Chronic,* or *Undefined*.
Comments	Use conventional word processing tools or Auto Replace text to enter any general comments about the patient problem, condition, or progress.
Additional tab	
Significance	Use the drop-down list to describe the problem's significance with respect to overall health: *Major Moderate, Minor,* or *Undefined*.
Severity/Intensity	Use the drop-down list to describe the problem's seriousness: *Mild, Moderate, Severe, Incapacitating,* or *Undefined*.
Stability	Describe the problem stability: *Stable, Unstable,* or *Undefined*.
Goal	Enter the goal regarding treatment or resolution of the problem.
Disability	Enter a description of the patient disability associated with the problem.
Reason for Change	Enter a reason for making the change.
Basis	Enter the reason for choosing the treatment or method for resolving the problem.

3. Click **OK**.

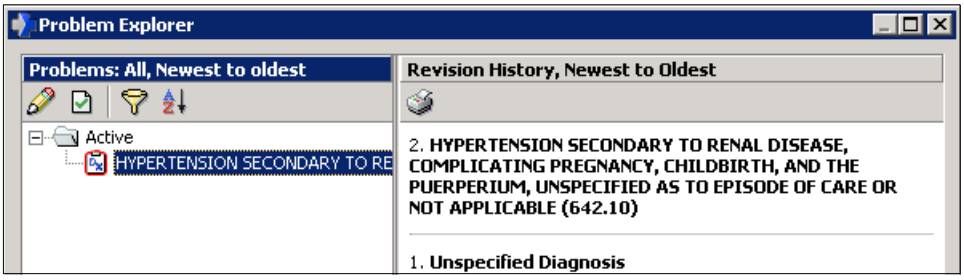
Changes to elements other than diagnosis classification are internal only. View the complete history, including changes, by double-clicking the problem on the patient face sheet or returning to the Problem Explorer.

To revise diagnoses from face sheets

1. In the *Problems* pane of the face sheet, select the problem and click (Edit Problem).
2. Click the **Diagnosis** search button ( ) in the upper right corner.



3. At *Search Term*, enter alpha or numeric characters to search for the revised diagnosis and click **Search**.
4. In *Search Results*, select the correct diagnosis and click **OK**.
5. In the Problem dialog box, click **OK** again.
   To see the problem history revision, double-click the item in the *Problems* pane of the face sheet.


Problem Explorer
Problems: All, Newest to oldest
Active
HYPERTENSION SECONDARY TO RE
Revision History, Newest to Oldest
2. HYPERTENSION SECONDARY TO RENAL DISEASE, COMPLICATING PREGNANCY, CHILDBIRTH, AND THE PUERPERIUM, UNSPECIFIED AS TO EPISODE OF CARE OR NOT APPLICABLE (642.10)
1. Unspecified Diagnosis

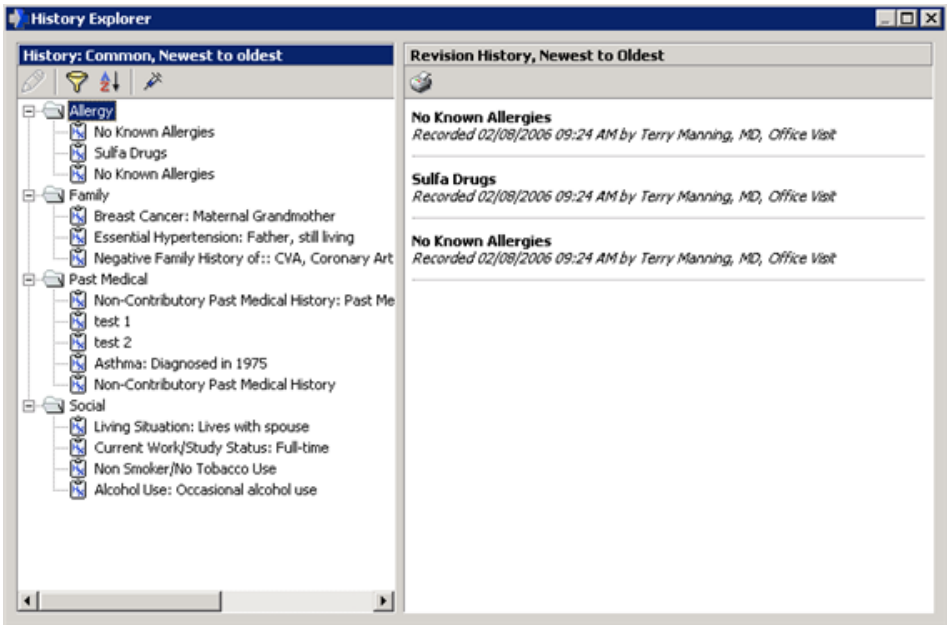
To print problems

1. Open a patient chart and, in the *Problems* pane, click (View Revision History) to display Problem Explorer.
2. In the left pane, select a folder or problem and in the right pane, click (Print).
   - **List** - To print a problem list, select a folder (**Active, Inactive** or **Resolved**).
   - **History** - To print the history of a specific problem, select the specific problem.

Viewing and revising history from face sheets

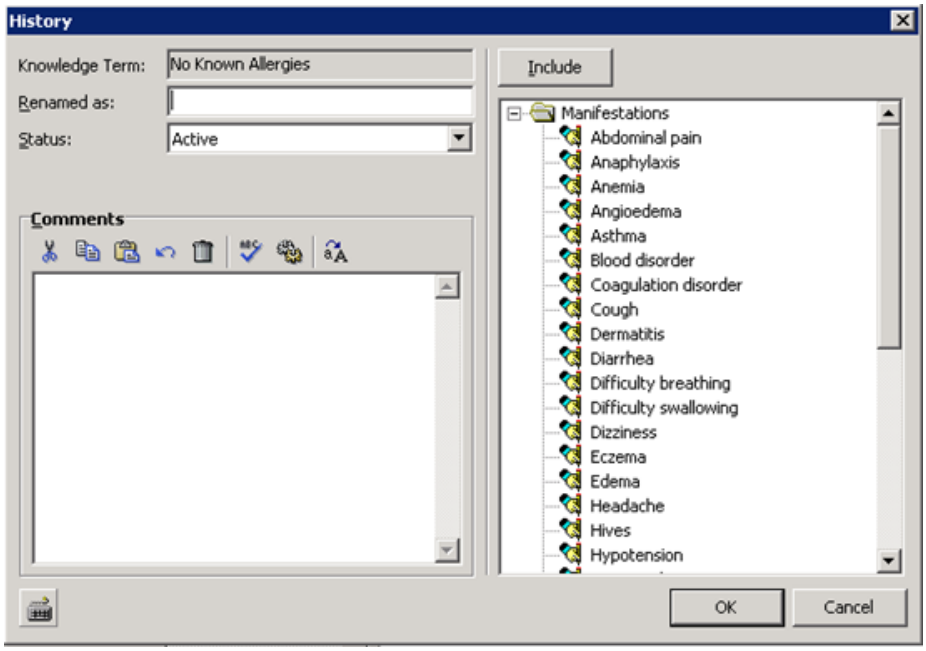
To view history

1. Open a patient chart, and in the *History* pane, click (View Revision History) to display History Explorer.


History Explorer
History: Common, Newest to oldest
Revision History, Newest to Oldest
Allergy
No Known Allergies
Sulfa Drugs
No Known Allergies
Family
Breast Cancer: Maternal Grandmother
Essential Hypertension: Father, still living
Negative Family History of:: CVA, Coronary Art
Past Medical
Non-Contributory Past Medical History: Past Me
test 1
test 2
Asthma: Diagnosed in 1975
Non-Contributory Past Medical History
Social
Living Situation: Lives with spouse
Current Work/Study Status: Full-time
Non Smoker/No Tobacco Use
Alcohol Use: Occasional alcohol use
No Known Allergies
Recorded 02/08/2006 09:24 AM by Terry Manning, MD, Office Visit
Sulfa Drugs
Recorded 02/08/2006 09:24 AM by Terry Manning, MD, Office Visit
No Known Allergies
Recorded 02/08/2006 09:24 AM by Terry Manning, MD, Office Visit

2. To view details, select an item.
   Click the **x** in the upper right corner to close History Explorer and return to the face sheet.

3. **To revise** a history item, select it and click (Edit History).



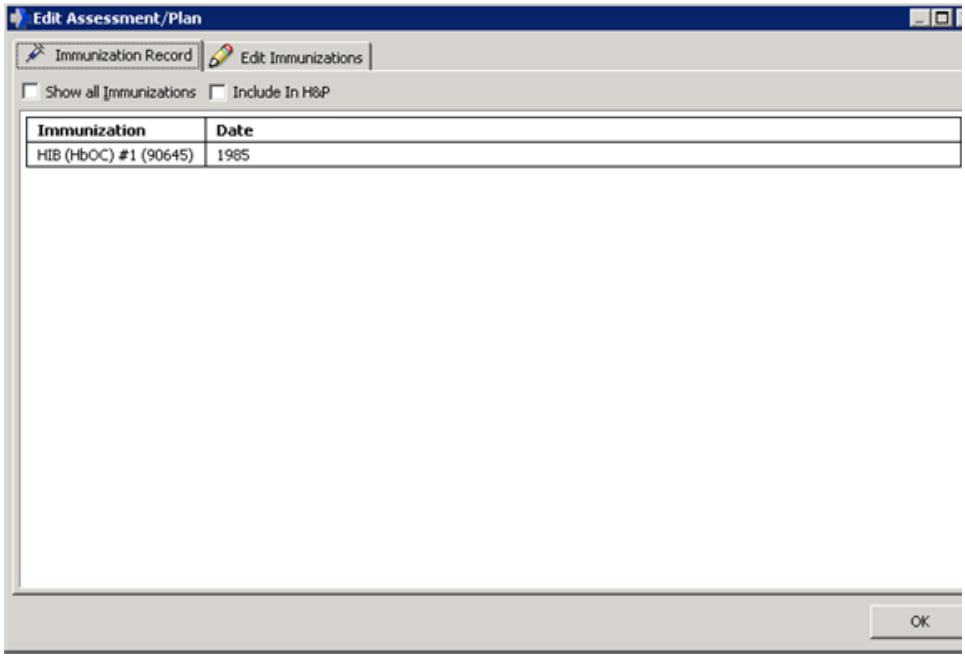
4. Change any of the following history details:
   - **Renamed as** - Type a new name for the history item, if desired.
   - **Status** - Click down-arrow to select a status: *Active, Inactive, Resolved, Erroneous Entry*, or *Undefined*.

     NOTE: Entries marked *Erroneous Entry* do not appear on the H&P Report.
   - **Include** - In the pane on the right, click (**+**) to expand folders and double-click details to include them in *Comments*.
   - **Comments** - Selections from the pane on the right display in the *Comments* text box. You can also enter free text and auto expand comments into this box.
5. Click **OK** to save changes and return to the face sheet.

To view/edit immunization history from face sheets

See Immunization Records on page 338 for full information and details.

1. From the History pane, click .



2. To view all immunizations, select the **Show all Immunizations** checkbox.
3. To include the Immunization Record in H&P select the **Include in H&P** checkbox.
4. **To edit immunization history** click **Edit Immunizations** tab.

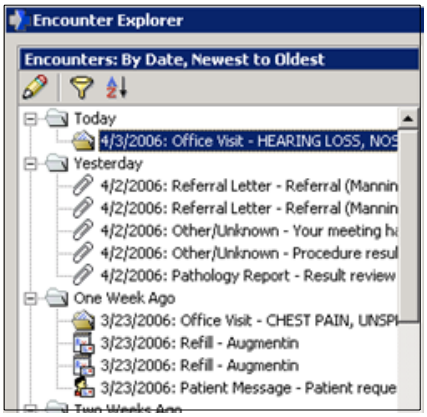
You can add historical immunizations here also. (See To add historical

immunizations on page 340, and Editing immunization history on page 339 for more information about editing immunization options from the face sheet.)

Viewing and revising encounters from face sheets

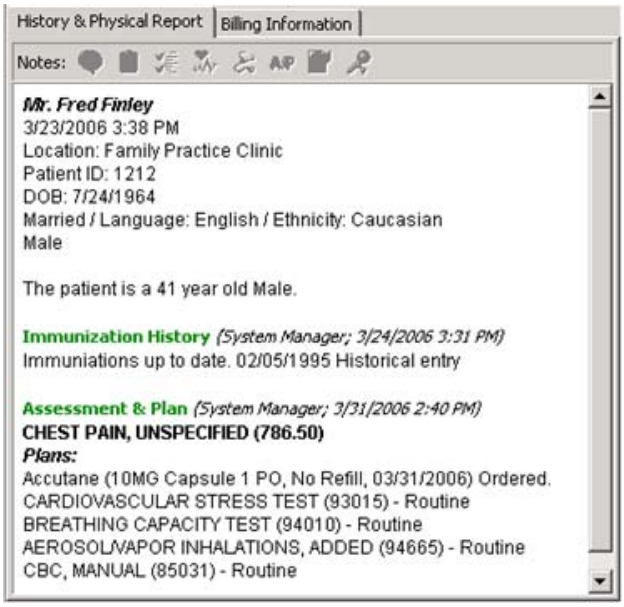
To view encounters

1. Pull a patient chart ***or*** click (Face Sheet) on the toolbar.
2. In the *Encounters* pane, click (View Encounter).
3. Click (Toggle Filter) to sort *By Type* (See Face Sheets on page 145.)

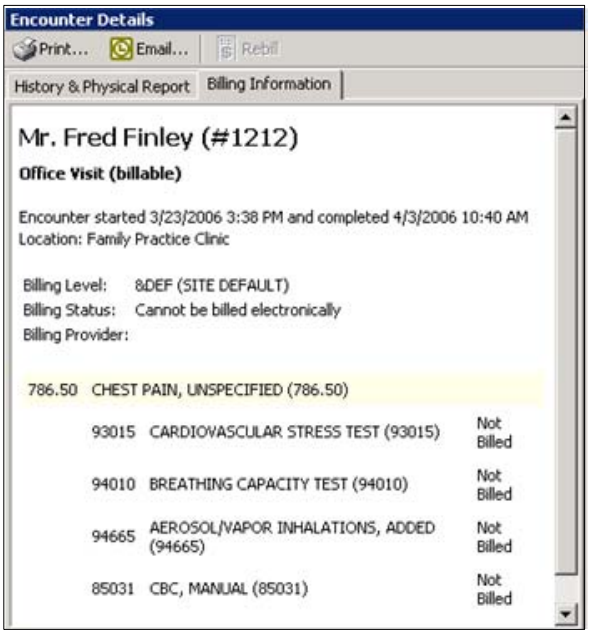

Encounter Explorer
Encounters: By Date, Newest to Oldest
Today
4/3/2006: Office Visit - HEARING LOSS, NOS
Yesterday
4/2/2006: Referral Letter - Referral (Mannin
4/2/2006: Referral Letter - Referral (Mannin
4/2/2006: Other/Unknown - Your meeting h
4/2/2006: Other/Unknown - Procedure resul
4/2/2006: Pathology Report - Result review
One Week Ago
3/23/2006: Office Visit - CHEST PAIN, UNSPI
3/23/2006: Refill - Augmentin
3/23/2006: Refill - Augmentin
3/23/2006: Patient Message - Patient reque

NOTE: Sorting *By Type* groups items by *Encounters, Messages, Chart Attachments*, *Scanned Documents,* and *Correspondence*.

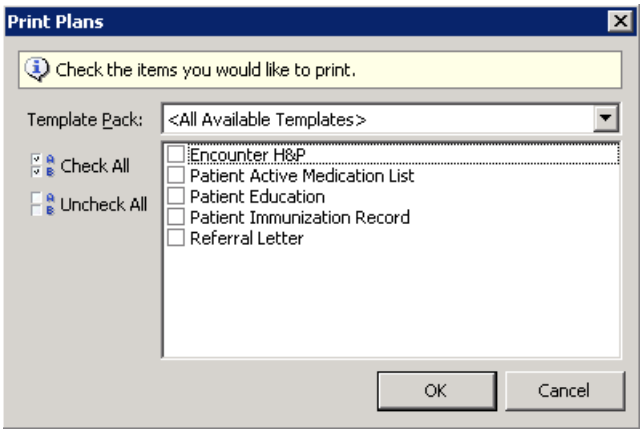
4. Click (**+**) to display the contents of the **Office Visit** folder.
5. Select an encounter date to view the H&P Report for that visit in the right pane.


History & Physical Report
Billing Information
Notes:
Mr. Fred Finley
3/23/2006 3:38 PM
Location: Family Practice Clinic
Patient ID: 1212
DOB: 7/24/1964
Married / Language: English / Ethnicity: Caucasian
Male
The patient is a 41 year old Male.
Immunization History (System Manager; 3/24/2006 3:31 PM)
Immuniations up to date. 02/05/1995 Historical entry
Assessment & Plan (System Manager; 3/31/2006 2:40 PM)
CHEST PAIN, UNSPECIFIED (786.50)
Plans:
Accutane (10MG Capsule 1 PO, No Refill, 03/31/2006) Ordered.
CARDIOVASCULAR STRESS TEST (93015) - Routine
BREATHING CAPACITY TEST (94010) - Routine
AEROSOL/VAPOR INHALATIONS, ADDED (94665) - Routine
CBC, MANUAL (85031) - Routine

- Click the **Billing Information** tab to see the billing level, status, and provider, as well as the items billed and not billed.


Encounter Details
Print...
Email...
Rebill
History & Physical Report
Billing Information
Mr. Fred Finley (#1212)
Office Visit (billable)
Encounter started 3/23/2006 3:38 PM and completed 4/3/2006 10:40 AM
Location: Family Practice Clinic
Billing Level: &DEF (SITE DEFAULT)
Billing Status: Cannot be billed electronically
Billing Provider:
786.50 CHEST PAIN, UNSPECIFIED (786.50)
93015 CARDIOVASCULAR STRESS TEST (93015) Not Billed
94010 BREATHING CAPACITY TEST (94010) Not Billed
94665 AEROSOL/VAPOR INHALATIONS, ADDED (94665) Not Billed
85031 CBC, MANUAL (85031) Not Billed

- Click **Print** to print the H&P Report or other items.



  Click the **Template Pack** down-arrow to select *<All Available Templates>* or *Typical Printouts*, then select the items to print and click **OK** to return to *Encounter Details*.

- Back in the Encounter Explorer, click **Rebill** to rebill the encounter,
- Click the **X** in the upper right corner to return to the face sheet.

To view approved SOAP and general transcription (external transcription)

SOAP transcription displays on patient History & Physical Report for the respective office visit. To view transcription on the H&P, follow the steps below:

1. From the HealthMatics EMR toolbar, click (Pull Chart), search for a patient with transcription, and double-click it to display the face sheet.

2. In the *Encounters* pane, click to sort *By Type*, and expand the *Encounters* and *Office Visit* folders.
3. Double-click the office visit for which notes were transcribed to view the History & Physical Report.

Items pertaining to transcription are marked *Transcription text* in the respective section(s) of the report.

To view voice notes (internal transcription) in the chart

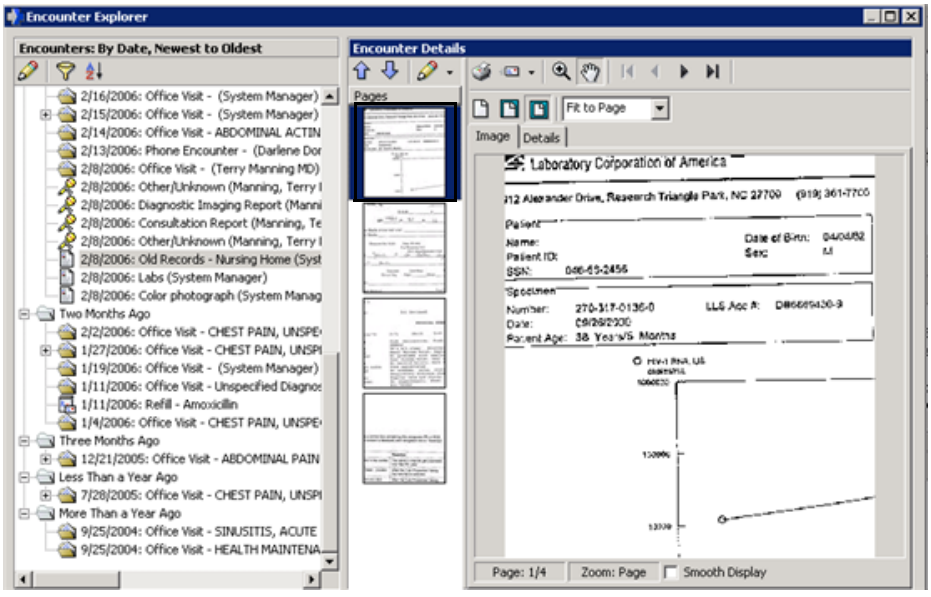
Voice notes display on the patient History & Physical Report for the respective office visit. To view the voice notes, follow the steps below:

1. On the HealthMatics EMR toolbar, click (Pull Chart), search for a patient with transcription, and double-click it to display the face sheet.
2. In the Encounters pane, click to sort By Type, and expand the Encounters and Office Visit folders.
3. Double-click the office visit for which notes were transcribed to view the History & Physical Report.

Contact screens with notes display as active icons at the tope of the window. Click the corresponding icon to read or listen to notes. Items pertaining to transcription are marked Transcription text in the respective section(s) of the report.

To view scanned documents in the chart

1. From the HealthMatics EMR toolbar, click (Pull Chart), search for a patient with scanned documents and double-click it to display the face sheet.
2. Click (View Encounter) to display Encounter Explorer.
3. Click (Toggle Filter) to sort *By Type*.


Encounter Explorer
Encounters: By Date, Newest to Oldest
2/16/2006: Office Visit - (System Manager)
2/15/2006: Office Visit - (System Manager)
2/14/2006: Office Visit - ABDOMINAL ACTIN
2/13/2006: Phone Encounter - (Darlene Dor
2/8/2006: Office Visit - (Terry Manning MD)
2/8/2006: Other/Unknown (Manning, Terry
2/8/2006: Diagnostic Imaging Report (Manni
2/8/2006: Consultation Report (Manning, Te
2/8/2006: Other/Unknown (Manning, Terry
2/8/2006: Old Records - Nursing Home (Syst
2/8/2006: Labs (System Manager)
2/8/2006: Color photograph (System Manag
Two Months Ago
2/2/2006: Office Visit - CHEST PAIN, UNSPE
1/27/2006: Office Visit - CHEST PAIN, UNSPI
1/19/2006: Office Visit - (System Manager)
1/11/2006: Office Visit - Unspecified Diagnos
1/11/2006: Refill - Amoxicillin
1/4/2006: Office Visit - CHEST PAIN, UNSPE
Three Months Ago
12/21/2005: Office Visit - ABDOMINAL PAIN
Less Than a Year Ago
7/28/2005: Office Visit - CHEST PAIN, UNSPI
More Than a Year Ago
9/25/2004: Office Visit - SINUSITIS, ACUTE
9/25/2004: Office Visit - HEALTH MAINTENA
Encounter Details
Pages
Fit to Page
Image
Details
Laboratory Corporation of America
Page: 1/4
Zoom: Page
Smooth Display

4. In the left pane, locate the document and select it to view.

5. In the center pane, click the thumbnail sketch to display the image on the right.
6. Click the icons above the image to move through the pages.

NOTE: You can also view approved scanned documents by sorting the encounters *By Date* and then selecting the appropriate item.

To move attachments/messages to other encounters

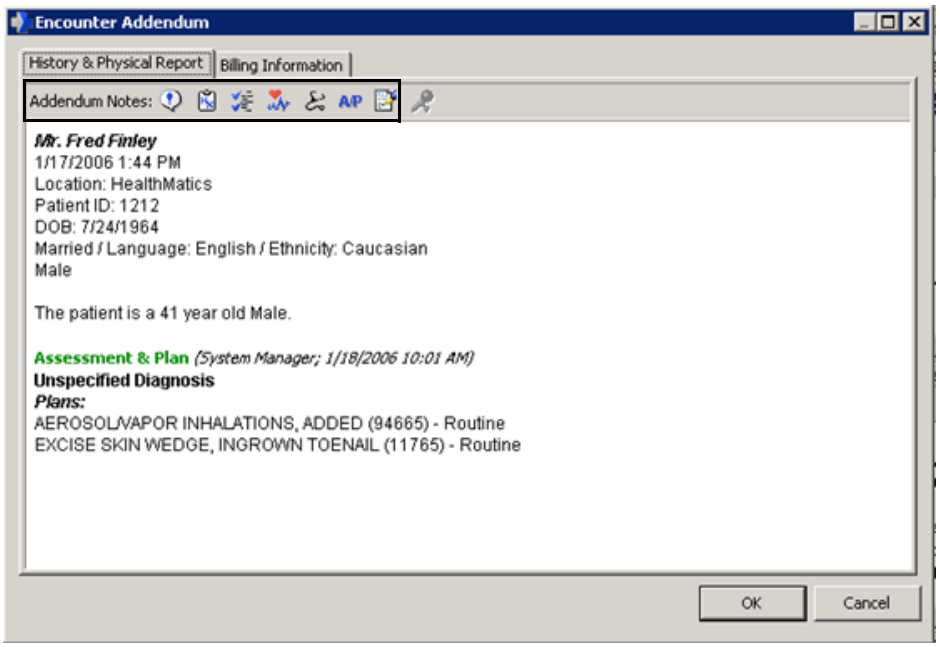
1. Open a patient chart, and on the toolbar, click (Face Sheet).
2. Click to maximize the *Encounters* pane and (Toggle Filter) to sort items *By Date*.
3. Click (**+**) to open an office visit with an attachment ( ) or patient message ( ).
4. Click and drag the item to a different Office Visit.

The item displays under the selected office visit on the face sheet.

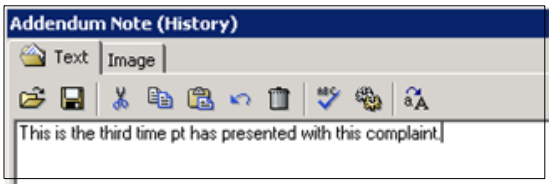
To change encounter information or create addenda

To include additional information for an encounter after it is completed and signed off, you can add notes as an addendum to the H&P report.

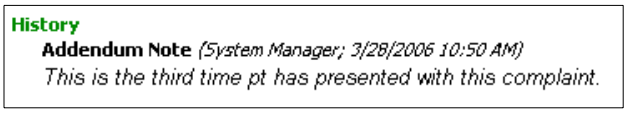
1. Open a patient chart, and from the toolbar, click (Face Sheet).
2. In the *Encounters* pane, highlight the office visit you want to add notes to and click (Edit Encounter).



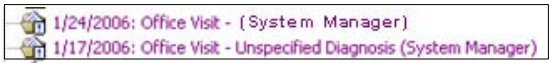
3. From the *Addendum Notes* box at the top of the window, click the H&P section icon you want to insert notes into.



4. Enter the note, then click **OK**.
   The information displays as an Addendum Note in the appropriate section of the H&P Report.



   In addition, the office visit displays in purple font in the Encounters pane on the face sheet, and an information symbol displays on the folder icon.

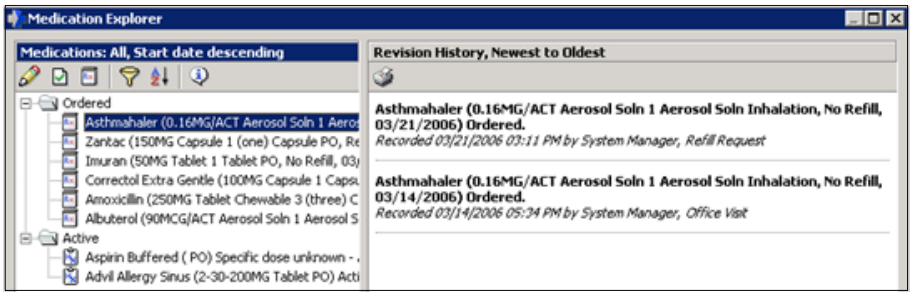


Viewing and revising medications from face sheets

Use the *Medication* pane on the face sheet to view and update information about patient medications. You can view history, inactivate, reactivate, or discontinue medications from the Medication Explorer.

1. Open a patient chart, and from the left pane ***or*** the toolbar, click (Face Sheet).

2. In the *Medications* pane, double-click an active medication ***or*** select it and click (View Revision History) to display the Medication Explorer.


Medication Explorer
Medications: All, Start date descending
Revision History, Newest to Oldest
Ordered
Asthmahaler (0.16MG/ACT Aerosol Soln 1 Aeros
Zantac (150MG Capsule 1 (one) Capsule PO, Re
Imuran (50MG Tablet 1 Tablet PO, No Refill, 03/
Correctol Extra Gentle (100MG Capsule 1 Capsu
Amoxicillin (250MG Tablet Chewable 3 (three) C
Albuterol (90MCG/ACT Aerosol Soln 1 Aerosol S
Active
Aspirin Buffered (PO) Specific dose unknown -
Advil Allergy Sinus (2-30-200MG Tablet PO) Acti
Asthmahaler (0.16MG/ACT Aerosol Soln 1 Aerosol Soln Inhalation, No Refill, 03/21/2006) Ordered.
Recorded 03/21/2006 03:11 PM by System Manager, Refill Request
Asthmahaler (0.16MG/ACT Aerosol Soln 1 Aerosol Soln Inhalation, No Refill, 03/14/2006) Ordered.
Recorded 03/14/2006 05:34 PM by System Manager, Office Visit

   All the patient medication displays in a list on the left.

3. To view the history of a medication, select it on the left to display the details on the right with the most current information at the top of the *Revision History* pane.

   NOTE: To view all medications with current orders, active, or inactive, highlight the respective folder in the *Medications* pane on the left.

4. In the *Medications* list on the left, select a medication and click the toolbar icons to do the following:

Icon	Name	Action
	Edit Medication	Click to display the Medication dialog box to change the *Status* of a medication (**Example:** to reactivate it) or other medication property information. See To order new medications on page 303.
	Inactivate Medication	Click to enter an inactivate date and move the medication to the *Inactive* folder.
	Refill Medications	Click to view the refill dialog to reorder medication.
	Toggle Filter	Click to toggle the view to show *All, Active, Inactive*, or *Discontinued* medications.
	Toggle Sort	Click to toggle the view to sort medications *Alphabetically, Start date ascending*, or *Start date descending*.
	View Interactions	Click to display the *Drug Interactions* dialog box to view detailed warnings about the patient's medication interactions.

To inactivate medications automatically

Medications can be inactivated automatically in the patient chart after the course date range has passed **IF** the medication order specified:

- # days to take the medication **and**
- Refills = 0.

Example: A medication such as a course10 day of Amoxicillin prescribed for an ear infection with zero refills will inactive automatically after 10 days pass.

Before listing the patient medications, the application checks for any medication courses that are complete and automatically inactivates them.

NOTES

- The revision history of a medication automatically inactivated displays an *Automatically inactivated* notation.
- This feature works only on medications ordered through Assessment/Plan and does not apply to historical entries unless the historical entry is managed.

Viewing orders from face sheets

You can view face sheet order results from two places:

- Orders pane
- Encounters pane (on a visit H&P Report)

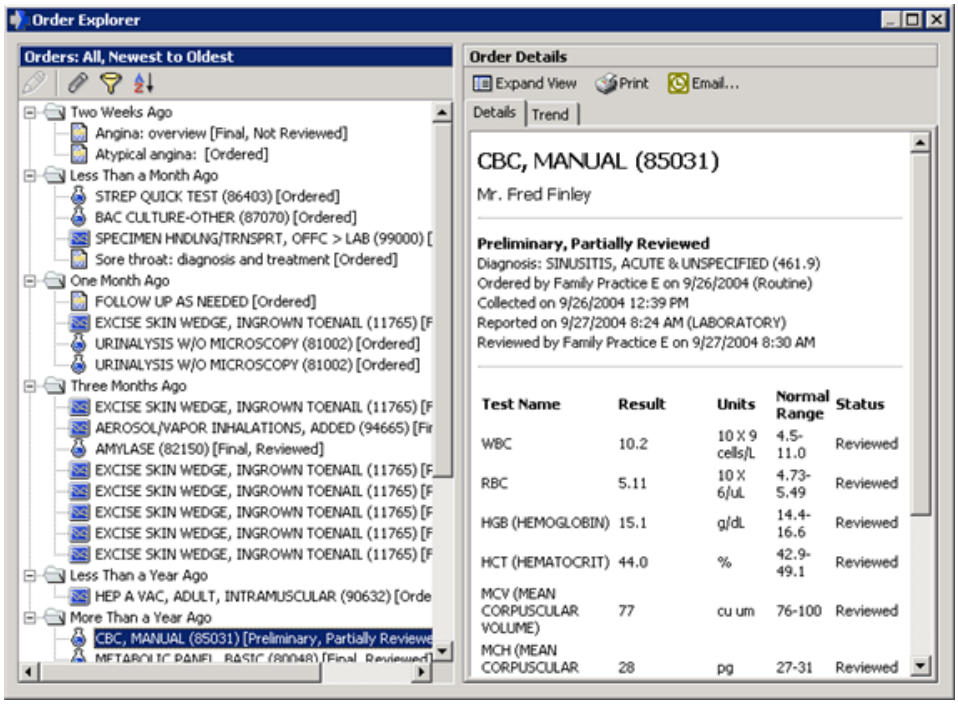
The *Orders* pane on the face sheet displays information about procedure and lab tests, referrals, and other orders. The system displays orders that are ordered, pending, need review, and are reviewed.

From the *Encounters* pane, you can access the H&P Report from a visit.

To view order results, pull a patient chart in HealthMatics EMR and from the left pane ***or*** the toolbar, click (Face Sheet) and do **one** of the following:

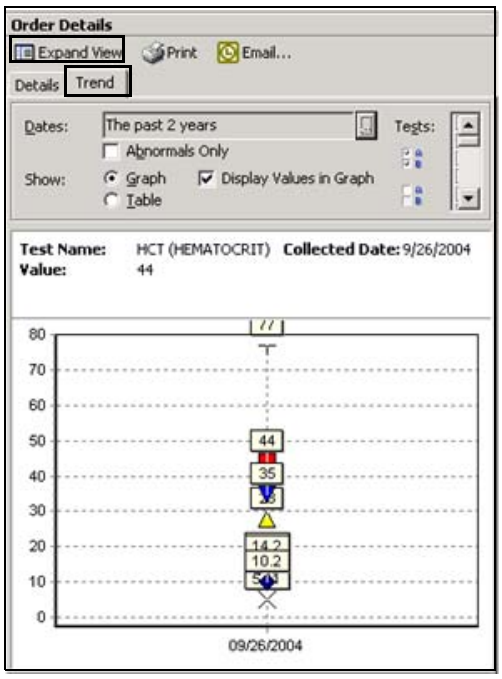
To view results from the orders pane

1. On the *Orders* pane toolbar, click (View Order).
2. Click (Toggle Filter) to toggle the view to either *All* or *Reviewed, Pending* or *Needs Review*.
3. Double-click an order that is *Preliminary, Partially Reviewed*, or *Reviewed* to display order information and results.



4. Details of the reviewed order display.

5. **(Optional)** Click the **Trend** tab to graphically represent order results.



6. **Expand view** - Toggles between full window viewing and navigation panel/split screen view.
7. **To print** - To print results, click , select a printer and click **OK**.
8. **Email** - click to select the email provider you want to use to send results.

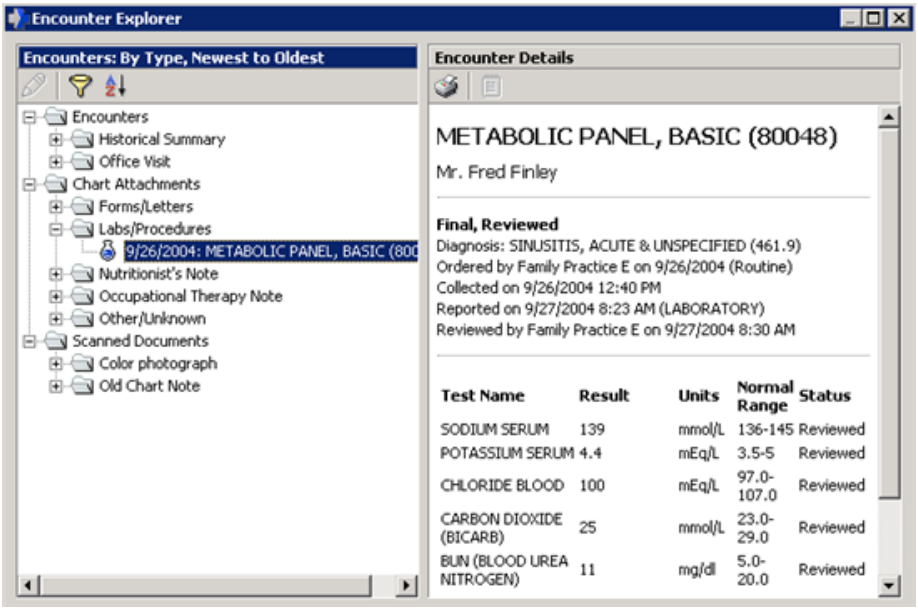
   NOTE: Make certain you meet HIPPA encryption requirements prior to emailing patient data.
9. **To attach to encounter** - To attach results to an encounter, click **Attach to Encounter** and choose from either the *Original, Current* or *Both* encounter(s).

10. Click **X** in the upper right corner to close window and return to the face sheet.

To view results from the encounter pane on H&P reports

1. On the Encounter pane right corner click to maximize it.
2. Expand the *Chart attachments* folder.

3. Expand the *Labs/Procedures* folder, then double-click the results you want to view.


Encounter Explorer
Encounters: By Type, Newest to Oldest
Encounters
Historical Summary
Office Visit
Chart Attachments
Forms/Letters
Labs/Procedures
9/26/2004: METABOLIC PANEL, BASIC (800
Nutritionist's Note
Occupational Therapy Note
Other/Unknown
Scanned Documents
Color photograph
Old Chart Note
Encounter Details
METABOLIC PANEL, BASIC (80048)
Mr. Fred Finley
Final, Reviewed
Diagnosis: SINUSITIS, ACUTE & UNSPECIFIED (461.9)
Ordered by Family Practice E on 9/26/2004 (Routine)
Collected on 9/26/2004 12:40 PM
Reported on 9/27/2004 8:23 AM (LABORATORY)
Reviewed by Family Practice E on 9/27/2004 8:30 AM
Test Name Result Units Normal Range Status
SODIUM SERUM 139 mmol/L 136-145 Reviewed
POTASSIUM SERUM 4.4 mEq/L 3.5-5 Reviewed
CHLORIDE BLOOD 100 mEq/L 97.0-107.0 Reviewed
CARBON DIOXIDE (BICARB) 25 mmol/L 23.0-29.0 Reviewed
BUN (BLOOD UREA NITROGEN) 11 mg/dl 5.0-20.0 Reviewed

4. Click **X** in the upper right corner to close window and return to the face sheet.
5. Click to return to the original face sheet view.

Demographics

IMPORTANT NOTE!

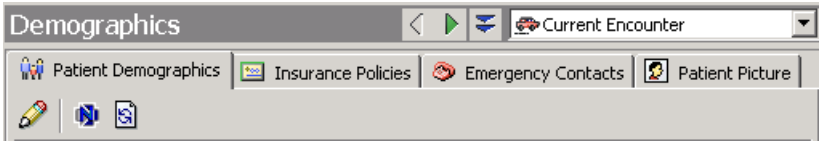
Patient demographics entered into your Practice Management System (PMS) always override demographic data entered into HealthMatics EMR. Therefore, most patient demographic information and all appointment, caregiver, and insurance carrier information should be entered into your practice PMS if you have one. If you enter basic demographic information into HealthMatics EMR, it will be overwritten when your PMS interface link to HealthMatics EMR is activated.

Your site administrator can prevent caregivers from updating demographic information within HealthMatics EMR by deselecting *Allow Demographics Entry* in **Administration Module > Settings > Site Settings**. When this setting is deselected, all fields that are overridden by your PMS become disabled (gray) and the **Add** button is hidden in Patient Search.

NOTE: If you do not have read/write privileges for the Demographics function, when you try to access Demographics, a message states, *Your account does not have the proper privileges to access this function*.

Accessing patient demographics

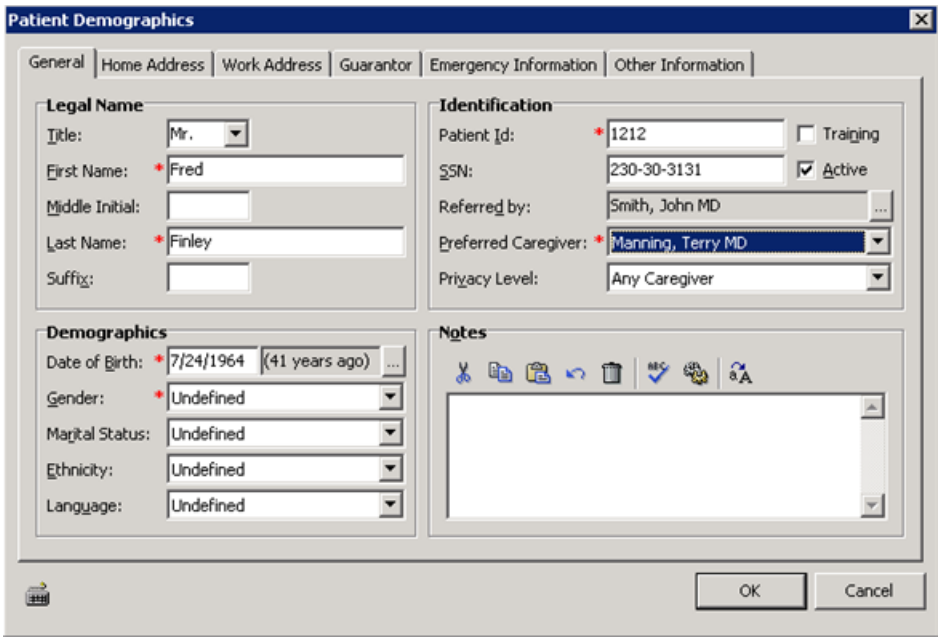
Access Demographics in one of two ways, depending upon whether the patient is established or not.



- To edit established patient demographics, with a patient chart open (name is on the title bar), from the left pane ***or*** the toolbar, click (Demographics), and then press **F2** or click (Edit Patient Demographics).
- To enter demographics for a new patient, from the toolbar, click (Pull a Chart), then at Patient Search, click **Add** (if it is not hidden).

Entering/editing patient demographics

1. Access Patient Demographics (see Accessing patient demographics on page 162).



NOTE: When adding patient demographics, required fields are preceded by red asterisks.

2. Complete fields as required/desired.
3. Click the **Referred By** search button ... to search for the referring caregiver.
   - Click the **Specialty** down-arrow and select a specialty ***and/or*** at *Name*, enter a few characters of the referring provider name and click **Search**.
   - Double-click the appropriate provider from the list ***or*** highlight it and click **OK** to assign that physician as the referring caregiver.

     NOTES
     *** Clear** resets *Specialty* back to <*All Specialties*> and clears the *Name* field.
     * If the referral caregiver is not in the database, click ✚ to add the caregiver.
4. Click the **Preferred Caregiver** down-arrow and select the patient primary caregiver for the practice.
   - To control access to a single patient chart, click the **Privacy Level** down-arrow and select additional privacy controls.
     > **Any caregiver** - Any caregiver with access to the location can pull the chart.
     > **Any caregiver (reason required if not preferred)** - Any caregiver with access to the location can pull the chart; however, if you are not the patient Preferred Caregiver of record, than you must first enter a reason for pulling the chart. Otherwise, it is locked.

> **Preferred caregiver, group and referral** - Only the *Preferred Caregiver*, and “referred to” caregivers can access the chart.
  - *Group* includes caregivers given grants to access the preferred caregiver inbox.
  - *Referral* includes caregivers to whom the preferred caregiver referred the patient in the *A/P* screen.

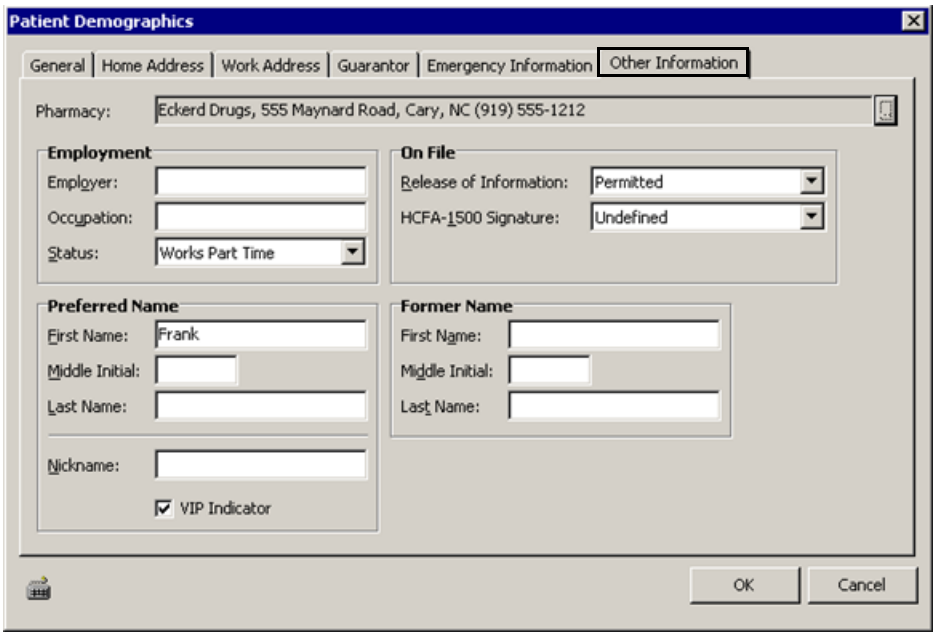
> **Preferred caregiver and referrals** - Only the *Preferred Caregiver* and *Referred by* caregivers identified as referrals can access the chart.

> **Preferred caregiver only** - Only the *Preferred Caregiver* of record can access the patient chart.

5. **Address tabs** - Click the **Home Address** and/or the **Work Address** tabs and enter all contact information.
6. **Guarantor tab** - If the guarantor is **not** the patient, click the **Guarantor** tab.
   - Click the **Relation to Guarantor** down-arrow and select the relationship.
   - Click **Other** to enable **Select** and access Guarantor Search.
   - Enter selection criteria and click **Search *or*** click **Add** to add a new guarantor to the database.

     NOTE: To edit guarantor information, click **Edit**.
   - In the *Search Results*, select the guarantor and click **OK** to return to the *Guarantor* tab.
7. **Emergency information tab** - To enter optional emergency information, click the **Emergency Information** tab and enter any of the following:
   - Blood type
   - Living will
   - Consent of care agreement
   - Organ donor
   - Patient is Deceased and Date of Death.
   - Additional comments

8. **Other information** - To enter other miscellaneous information, click the **Other Information** tab.



- **Pharmacy** - To enter a patient preferred pharmacy, click the **Pharmacy** search button (...) and do the following:

  > Enter criteria in any of the search fields and click **Search**, select the pharmacy then click **OK** ***or***

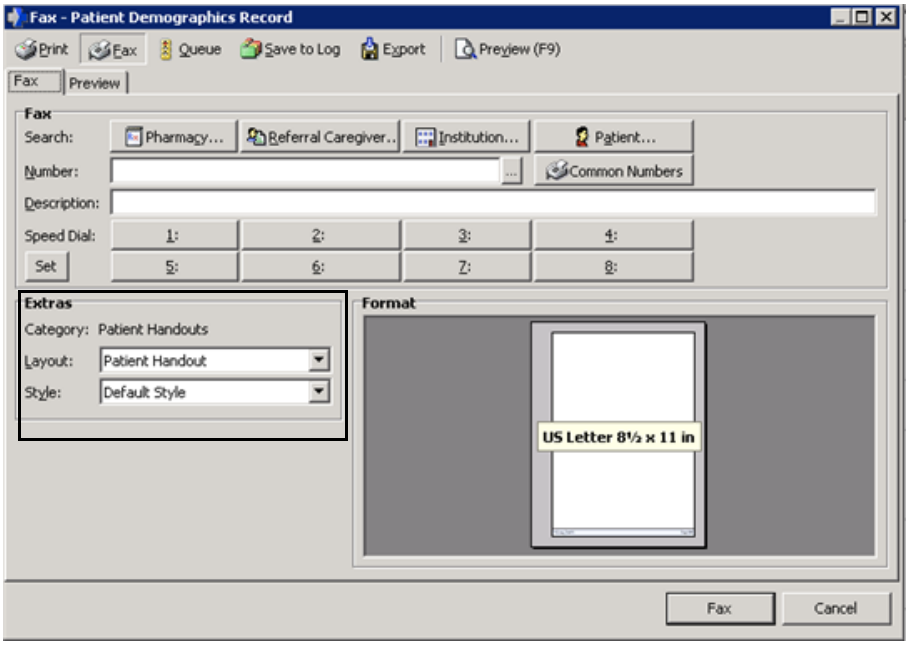
  > Click to add a new pharmacy to the database, complete the fields, then click **OK**.

- **VIP** - Select the **VIP Indicator** to indicate the patient is a *very important person.* (See also To customize the title bar on page 125.)

9. Click **OK** to save and view all patient demographics.

Printing patient demographics

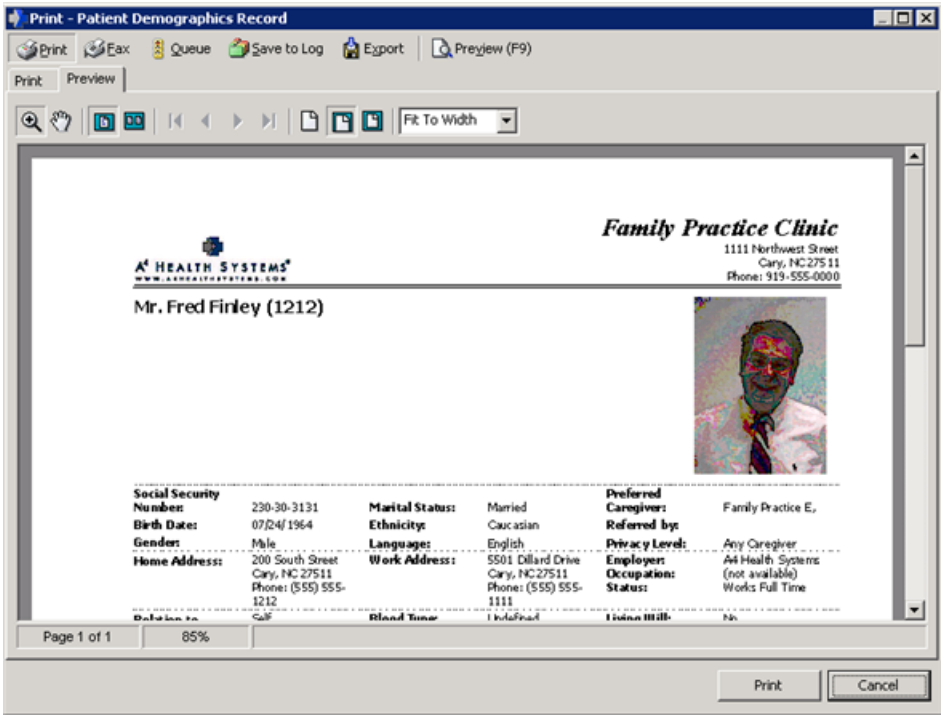
1. With a patient chart open, click (Demographics), then from the application toolbar, click **> Patient Demographics Record (Fax)**.



2. Select a different output method as needed: **Print**, **Queue**, **Save to Log**, **Export**.
3. From *Extras* click the *Layout* drop-arrow to select a layout to print demographics.

   NOTE: These layouts are created and edited via Output Manager.
4. Select a font *Style* if your practice has more than one defined.

5. Click the **Preview** tab or the (Preview) icon from the secondary toolbar to preview the output.



6. Click the action button (**Fax**, **Print**, **Queue**, **Save to Log**, **Export**)

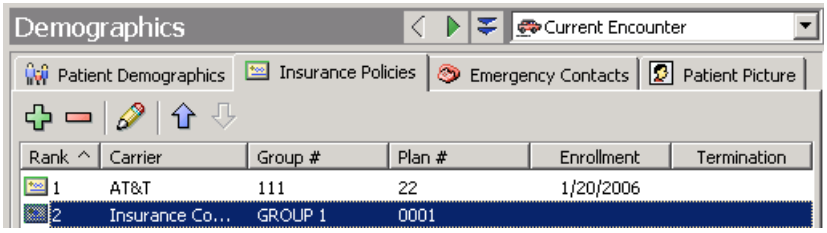
7. Refer to Printing chapter.

Entering patient insurance information

If you have a Practice Management System (PMS), enter all patient insurance information into the PMS. If you do **not** have a PMS, enter patient insurance information into *Demographics*.

1. Open a patient chart, and from the left pane ***or*** the toolbar, click (Demographics).

2. Click the **Insurance Policies** tab.



NOTES

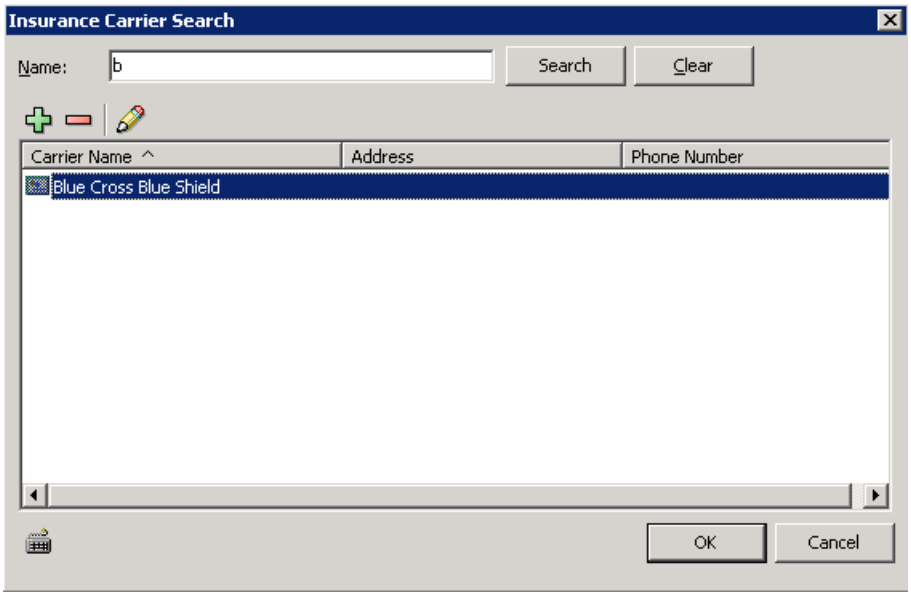
***** If the patient has multiple insurance policies, the number in the *Rank* column indicates whether the policy is primary (**1**), secondary (**2**), or tertiary (**3**).

* To change policy priorities, select a policy and, on the secondary toolbar, click the up or down arrow.

* For a description of the secondary toolbar icons, see Using secondary toolbar icons and shortcut keys on page 9.

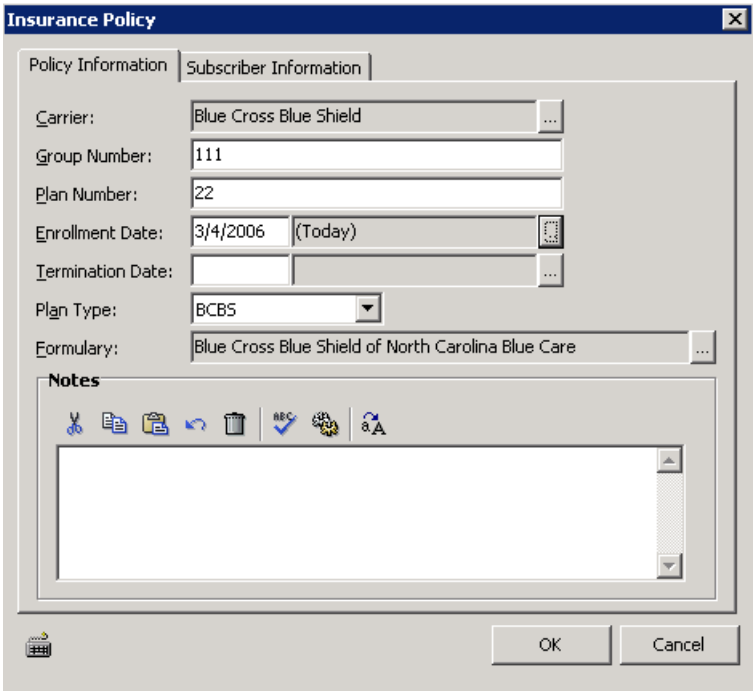
3. **To add a new policy,** press the **Insert** key ***or***, from the secondary toolbar, click (Add Policy).

4. On the *Policy Information* tab, click the **Carrier** search button ( ), and search for the patient carrier.



NOTE: If the patient carrier is not in the database, enter it into your PMS ***or*** if you do **not** have a PMS, follow the instructions in To add insurance carriers on page 169.

5. Click **OK** to return to Insurance Policy properties.



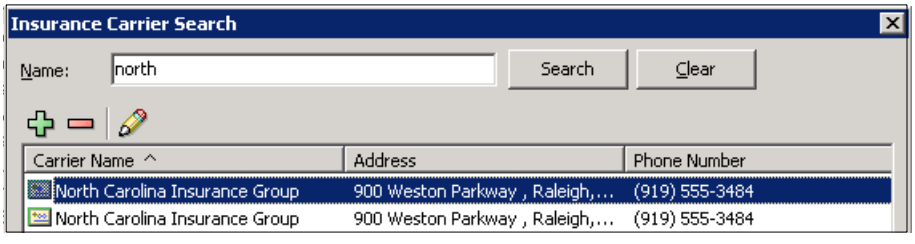
6. Enter the *Group Number, Plan Number, Enrollment Date* and *Plan Type*.
7. **IF** the policy subscriber is **not** the patient, click the **Subscriber Information** tab to enter the relationship of the subscriber to the patient.
   - Click the **Relation to Subscriber** down-arrow and select the relation to display additional fields.
   - Enter the subscriber's information and click **OK**.

To enter insurance carriers into the EMR database

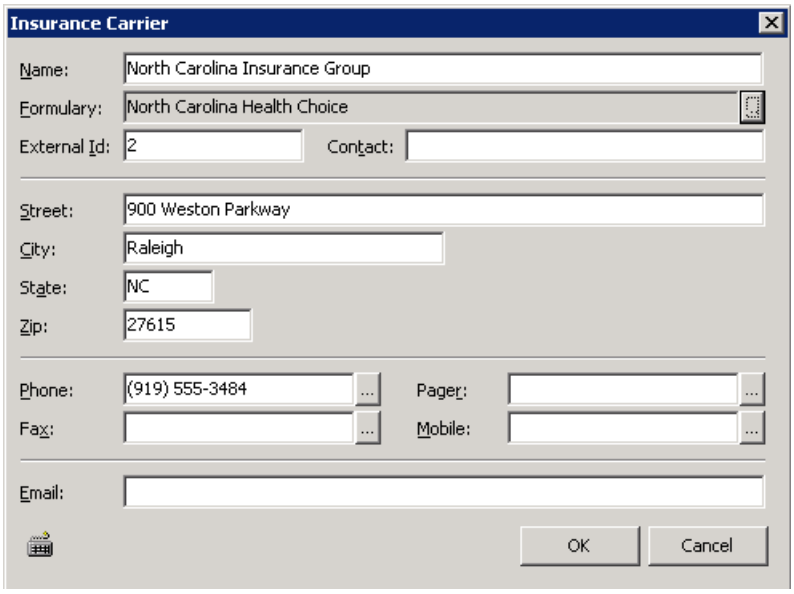
To add insurance carriers

IF you do **not** have a PMS, you can add carriers to the EMR database by following the steps below:

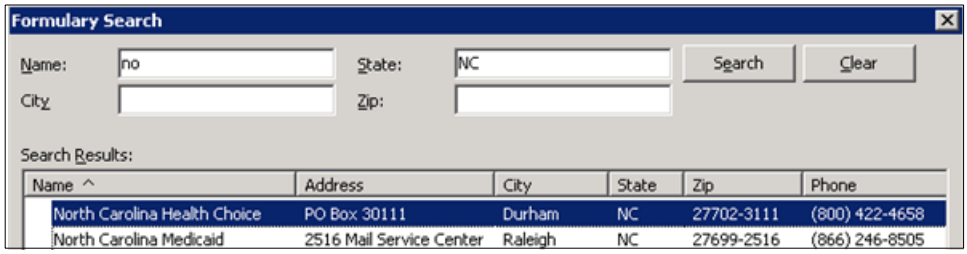
1. From the menu bar, select **Tools > Edit Insurance Carriers**.



2. Press the **Insert** key on your keyboard or click (Add Insurance Carrier).



3. At *Name*, enter the carrier name.
4. Click the **Formulary** search button ( ).



Search for, and select the appropriate formulary for the carrier you are adding, then click **OK** to return to the Insurance Carrier dialog.

5. Enter the remaining information in the appropriate fields and click **OK** to display the new carrier in the Insurance Carrier Search.
6. Click **Close**.

To edit insurance carrier information

IF you do **not** have a PMS, you can edit carrier information in the EMR database by following the steps below:

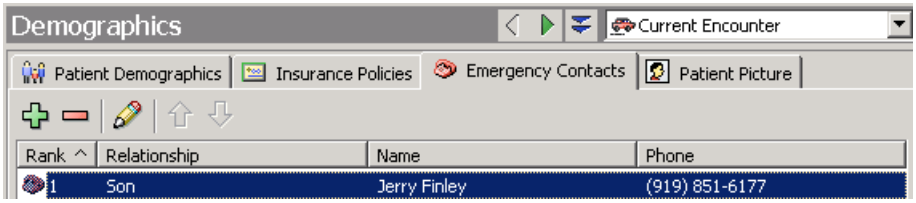
1. From the menu bar, select **Tools > Edit Insurance Carriers**.
2. In Insurance Carrier Search, search for the insurance carrier, select it and click .
3. In Insurance Carrier, edit information as needed and click **OK**.
4. Click **Close**.

IMPORTANT NOTE!

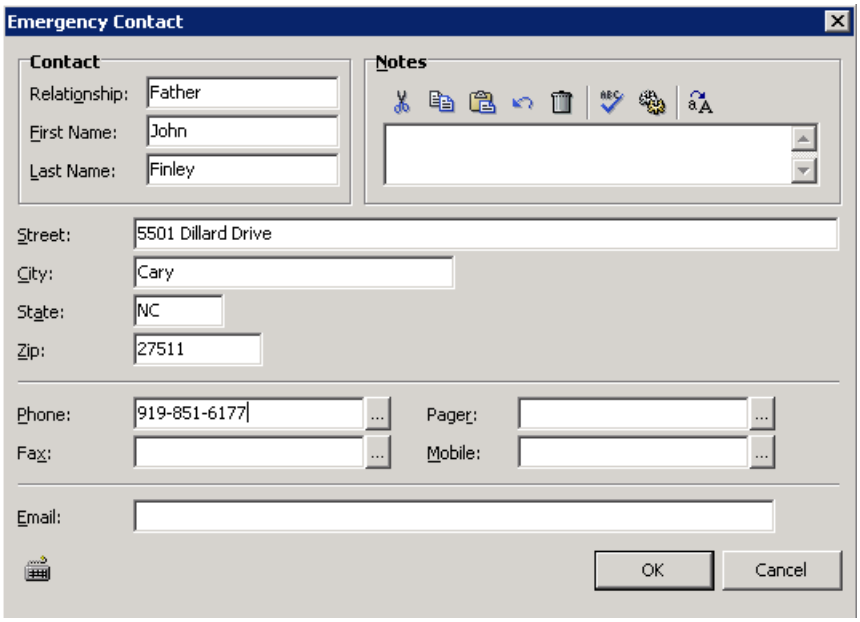
If *Allow Demographics Entry* in **Launch > Administration Module > Settings > Site Settings** is *Off*, secondary toolbars on the *Insurance Policies* and *Emergency Contacts* tabs do not display, since that information cannot be edited from HealthMatics EMR. The (Edit Patient Demographics) button on the Demographics screen still displays, but when you click it, fields updated by the PMS interface are disabled (gray), and you will only be able to modify fields that are not updated by your PMS.

Entering emergency contacts

1. Open a patient chart, and from the left pane ***or*** the toolbar, click (Demographics) then click the **Emergency Contacts** tab.



2. **To add** emergency contacts, press the **Insert** key ***or*** from the secondary toolbar, click (Add Emergency Contact).



   Enter information as appropriate and click **OK**.

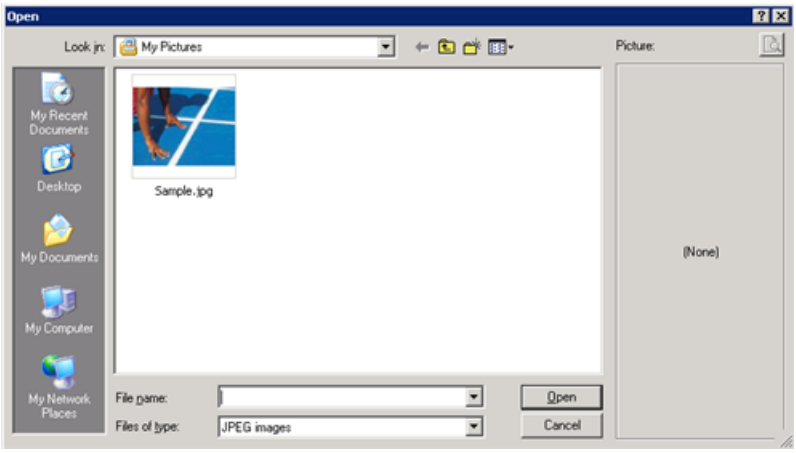
3. **To edit** contacts, on the *Emergency Contacts* tab, select the contact and click (Edit Emergency Contact).

4. Edit as needed and click **OK**.

Loading patient pictures

NOTE: To enter patient pictures into the EMR, you must have them stored as files in your database.

1. With a patient chart open, from the left pane ***or*** the toolbar, click (Demographics) and select the **Patient Picture** tab.
2. Click (Edit Picture).
3. In Patient Picture, press **Insert** on your keyboard ***or*** click (Load picture from file).



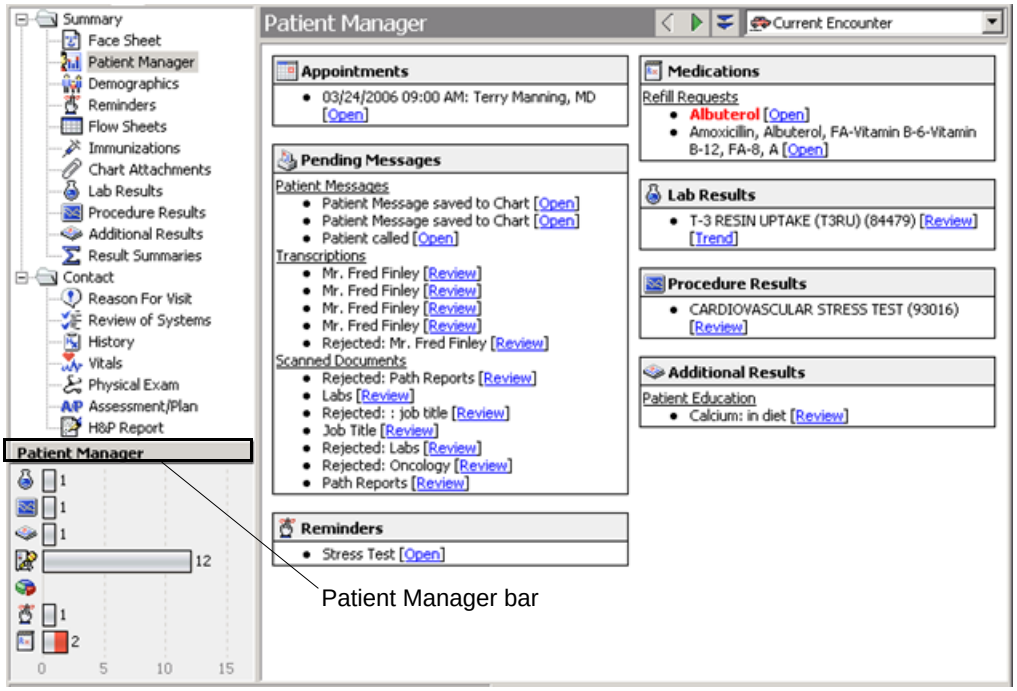
- Click the **Look in** down-arrow and navigate to the patient picture (if you have one scanned into your database).
- Select the picture file and click **Open**.

Patient Manager

To provide a single place to manage patients outstanding medical record items and to view reminders for preventive health maintenance needs, HealthMatics EMR provides the Patient Manager view.

Patient Manager lists all items awaiting review for a selected patient, including results, documents, and transcriptions. The Patient Manager view also lists pending messages, refill requests, and health maintenance and disease management reminders for the patient. Patient Manager provides hyperlinks to screens that need review, trends, schedules, orders, or refill items.

To access this view, with a patient chart open from the left pane, select **Patient Manager** ***or*** click the **Patient Manager** bar in the lower left corner of the screen.



In the *Patient Manager* view, the bars in the lower left corner reflect the number of items awaiting action for the selected patient. Items that are overdue, high priority, or include abnormal results, display in **red** in both the *Patient Manager* bars and the preview pane to the right.

The following types of messages may appear in the *Patient Manager* view.

Message Type	Description
Appointments	Future scheduled appointments. Click **Open** to view appointment and edit details (see Appointments on page 15).
Pending messages	• **Patient messages** - Patient messages not *Saved to Chart* or deleted, plus high priority **(red)** items. Click **Open** to view (see Responding to patient messages on page 40). • **Transcriptions** - Transcriptions not yet reviewed. Click **Review** to mark item *Reviewed* (seeApproving or rejecting documents on page 71). • **Scanned documents** - Scanned documents not reviewed. Click **Review** to mark item *Reviewed* (seeTo approve or reject scanned documents on page 74.
Reminders	Health maintenance/disease management and other chart reminders, such as reminders for flu shots or immunizations - Click **Open** to view (see Reminders on page 211).
Medications	Pending refill requests (in **red** if high priority) - Click **Open** to view and approve a refill request (see Refill Requests on page 44).
Lab results	Results with the status of *Final* or *Needs Review* (in **red** if abnormal). • Click **Review** to open the Review Lab Results dialog. • Click **Trend** to open the Lab Trends dialog. See Reviewing lab results on page 178.
Procedure results	Results marked *Final* or *Needs Review* (in **red** if abnormal) - Click **Review** to review the results (see Reviewing procedure results on page 191).
Additional results	Referrals, authored text, and patient education not marked complete *(Final)* - Click **Review** to finalize the document (see Additional Results on page 195).
Report results	Health maintenance and disease management reports that include an action item for the patient - Click **Edit** to view task details. • **Task** tab - Click the **Task** down-arrow to indicate what was done (**Examples:** Called Patient, Ordered, Send Letter) and enter comments in the text box, then select **Completed**. • **Contact/values** tab - Patient contact information, such as address, phone numbers, age, and gender. • **History** tab - History of actions taken. Click **Quick A&P** to document orders, plan or treatment without closing the Patient Manager view (see Report Results on page 198).
Pregnancy Record (for female patients of child-bearing age only)	Displays for patients with an active procedure of 59400 routine Obstetric Care. Patient *LMP* (last menstrual period) date, *EDD* (estimated delivery date), *Blood Type, Gestational Age* and *Gravidity/Parity* (# of pregnancies, # of live births) - Click **Edit** to access the Pregnancy Record (seePregnancy Record on page 322),

See also To set patient manager defaults on page 116.

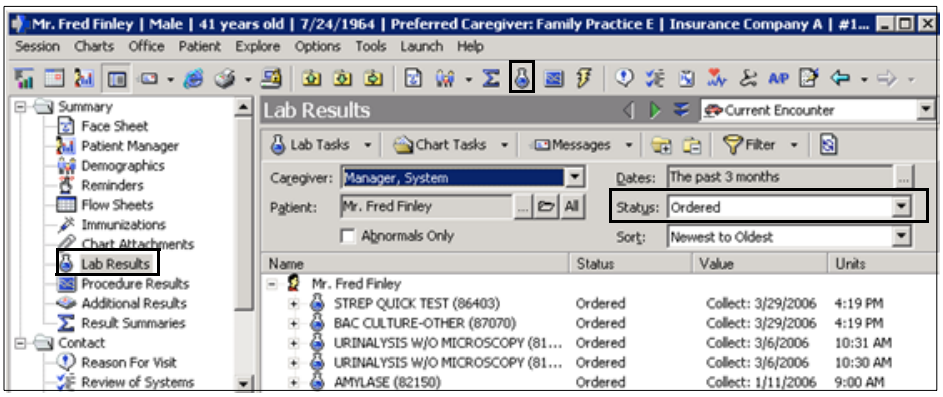
Lab Results

You can enter lab results, submit results to providers for approval, and save results to patient charts. Lab Results features are similar to Procedure Results. You can send messages about results to caregivers and you can attach them to patient charts.

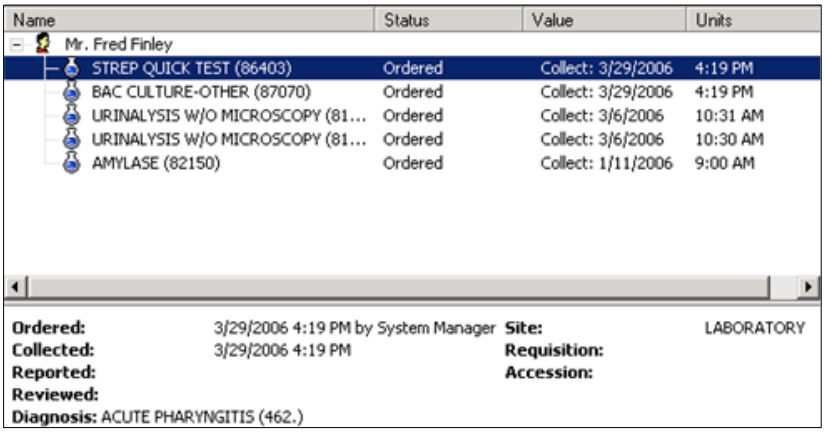
Entering lab results

To manually enter lab results into HealthMatics EMR, take the following steps.

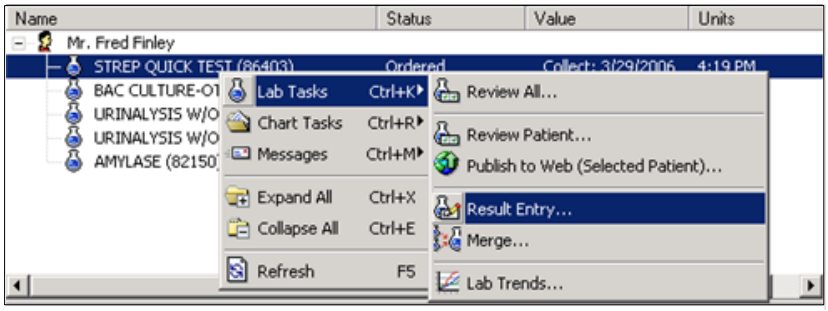
1. With a patient chart open, from the HealthMatics EMR toolbar click (View Lab Results), ***or*** from the menu bar, select **Office > Lab Results** or from the left navigation pane, click Lab Results.



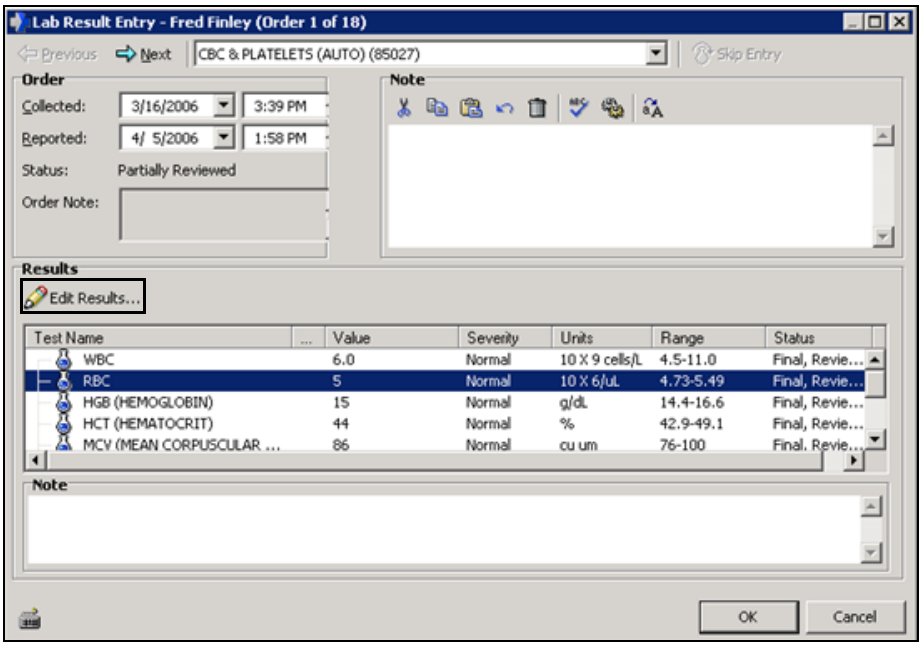
2. At *Status*, select *Ordered*.
3. Select *Caregiver, Patient, Dates, Sort* as needed.
4. Click (**+**) or to expand and display patient labs, then select the one you want to enter results into. Details display in the preview pane at the bottom of the screen.

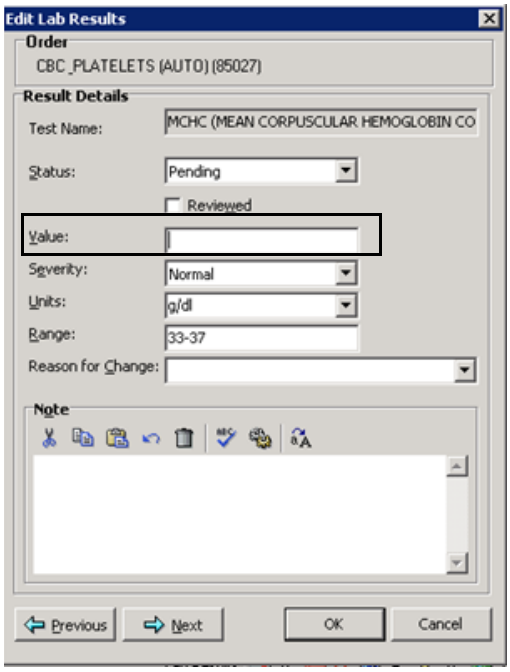


5. On the secondary toolbar (or right-click for a menu), click **Lab Tasks > Result Entry**.



6. From Lab Result Entry, click (Edit Results)





7. At *Value*, enter results. A Note can be added if desired, using conventional word-processing tools.

   NOTE: Value selection lists can be created in the Lab Catalog. (See the HealthMatics EMR ***Clinical Customization*** manual.).

Field	Description
Value	Value reported for the test result. If abnormal results are entered, the *Profile/Panel/Test* on the left displays in red.
Severity	If a normal *Range* has been specified, the field defaults automatically to *Normal,* or *Abnormal* if the value is outside the normal range specified. You can also click the down-arrow to select the appropriate severity of the result value for the selected test.
Units	If appropriate, click the down-arrow to select units for the result value.
Range	Displays the normal range for that item.
Reason for Change	If you are changing a lab results entry, click the down-arrow to select a reason for the change or enter a free text reason.
Note	Enter a note for the lab test if desired. **NOTE:** If your practice receives results over a bi-directional lab interface, result values automatically populate the Result Details as they are received and matched by the Lab Reconciler.

8. Continue entering results for this lab or panel by clicking Next or press **Alt+N** on your keyboard. When all results for the selected lab test or panel are entered, the **Next** button will display grayed out.
9. Click **OK**.

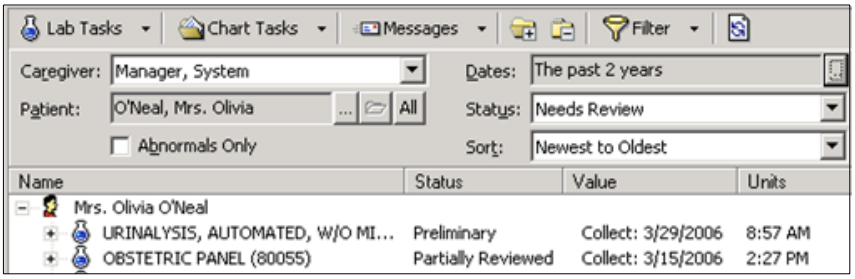
   NOTE: To enter next lab test result without exiting this window, click Next for the next lab to display or click the *Next* down-arrow to select a test from the drop-down list.

Reviewing lab results

You can view lab results when you receive a Review Results notification, mark results *Reviewed*, and send messages to other caregivers who may need to review results.

To review lab results from review results

1. From the HealthMatics EMR Status bar, click (Review Results), then double-click the patient name on the list displayed, ***or*** select it and click (Open).

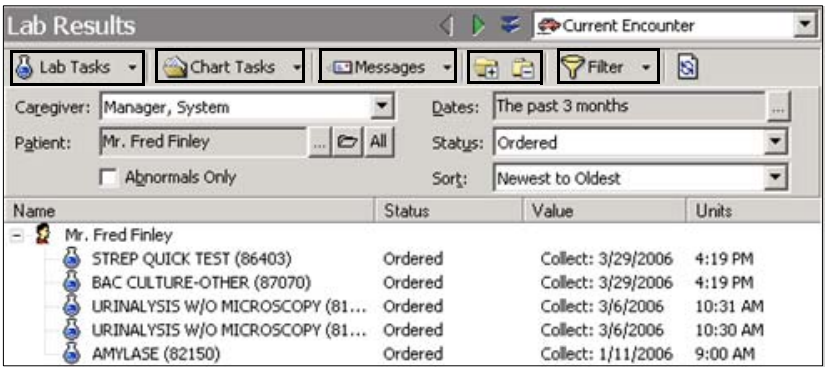


2. Double-click the test to view results.
3. To mark results *Reviewed*, see To review lab results on page 178.

To review lab results

1. With a patient chart open, from the HealthMatics EMR toolbar click (View Lab Results), ***or*** from the menu bar, select **Office > Lab Results** or from the left navigation pane, click Lab Results

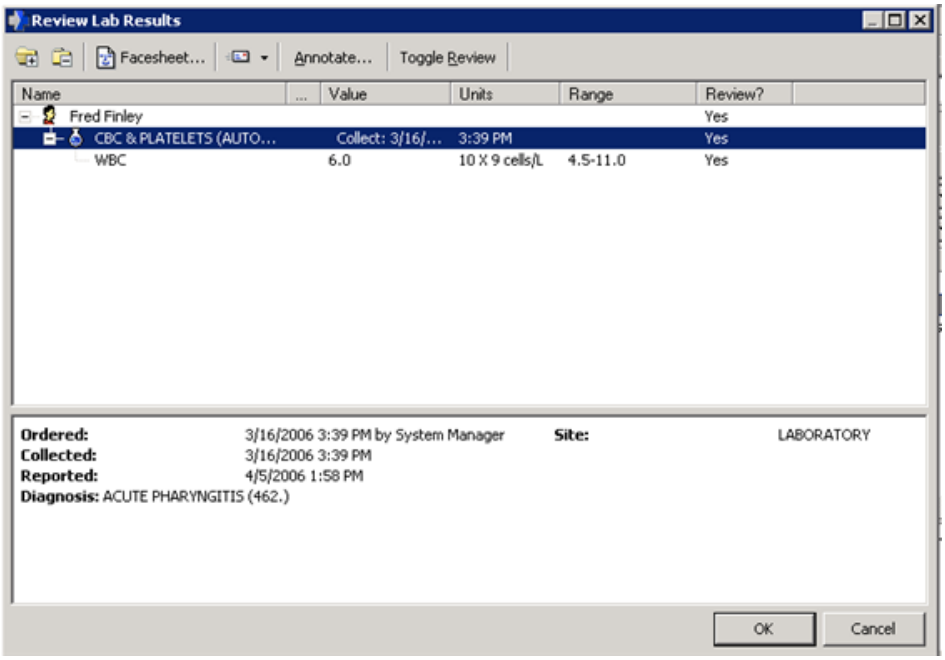
.**NOTE: Office > Lab Results** views all patients.



Icon	Name	Action
	Lab Tasks	Click down-arrow and select: • **Review All** - Displays *Review Lab Results* dialog. • **Review Patient** - displays lab results for the selected patient. • **Publish to Web** - Publish patient test results to the practice website (if you purchased and connected HealthMatics EMR Access). For detailed instructions, refer to the ***HealthMatics Access Manual***. • **Result Entry** - Enter the results or Result Notes (see Entering lab results on page 175). • **Merge** - Merge lab results from the Lab Interface with results on the Labs view. A dialog box displays where you can select the test and merge it with the result. • **Lab Trends** - Display results in a graph or table.
	Chart Tasks	Click down-arrow and select: • **Pull Chart** - Pull the patient chart. **NOTE:** Closes Lab Results. • **Face Sheet** - View the patient face sheet. **NOTE:** To return to Lab Results, click **X** in the upper right corner. • **Attach to Encounter** - Attach the lab result to the H&P for the original encounter, current encounter or both.
	Messages	Click down-arrow and select: • **Send Patient Message** - Send a patient message to another caregiver about the lab results. • **Send Web Message** - (Only available if you purchased and connected HealthMatics EMR Access.) Send a message to the patient via the website. • **Send Reminder** - Place a reminder on the patient chart.
	Expand All	Click to view all lab tests/results.

Icon	Name	Action
	Collapse All	Click to collapse all the results.
	Select a Filter	Click down-arrow and select: • System Default • List of up to eight custom filters • Set Filter • Set User Default
	Refresh (**F5**)	Click to refresh the view to include any recent changes.

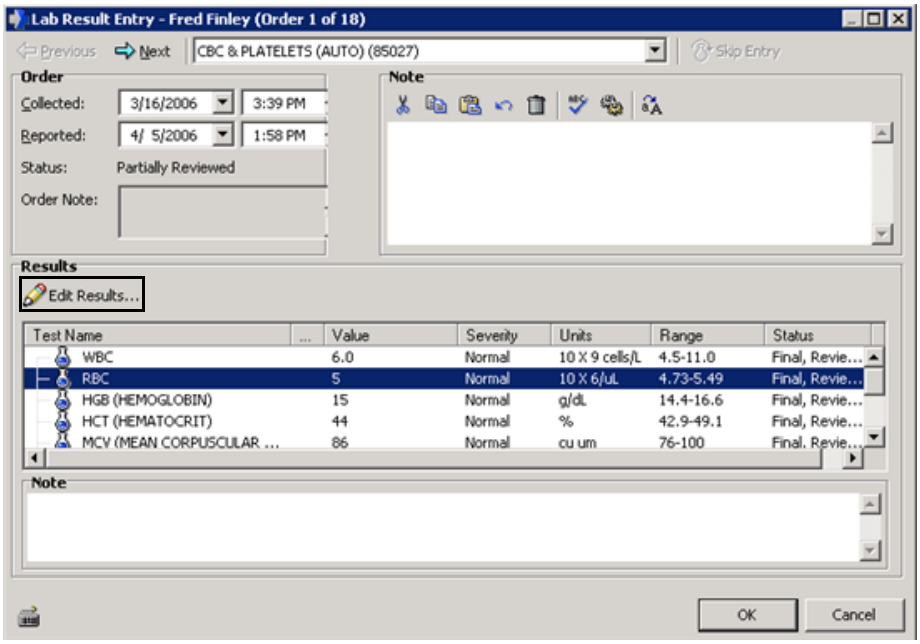
2. Click **Expand All**.
3. At *Status,* click the down-arrow and select *Needs Review.*
4. Select the test for review, then from the secondary toolbar, click **Lab Tasks > Review Patient**.



Icon	Action
	Click to Expand All and view values for each test.
	Click to collapse all and view only patient names.
	Click to display the selected patient face sheet. **NOTE:** To return to Lab Result Review, click the X in the upper right corner.
	Click to create a patient message, web message, or reminder on the patient chart. (See Reviewing lab results on page 178 and Creating reminders on patient charts on page 211.)

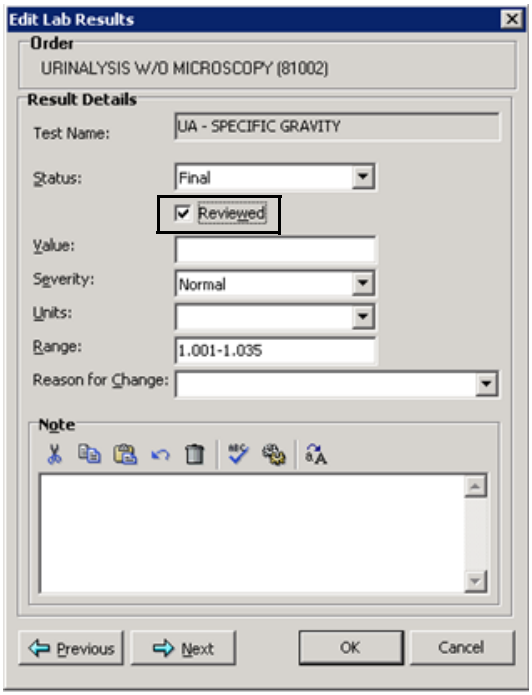
Icon	Action
Annotate	Click to enter interpretive comments while reviewing Lab results in a Note for the selected lab. (See Annotating lab results during review on page 183.)
Toggle Review	Click to toggle *Review?* from *Yes* to no entry.
Toggle Published	**(HealthMatics Access option)** - Click to toggle the selected results from *Published* to *Not Published*.
Web Comment	**(HealthMatics Access option)** - Click to publish a comment about the results to the web and/or request a Read Receipt for notification when the patient opens the test result from the website. *Yes w/RR* displays in the *Published* column. An automated message gets delivered to your HealthMatics EMR Inbox when the patient opens the lab results from the website.

5. Click **OK** to save the Reviewed Status.



6. Double-click the test name to view the actual results.

7. Click (Edit Results).

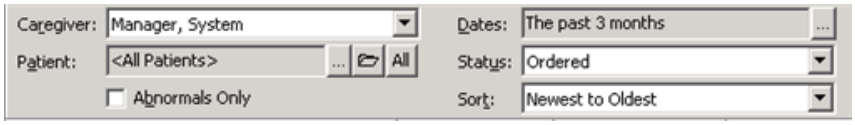


8. To mark the lab result reviewed, click the *Reviewed* checkbox.
9. Click **OK** to return to Lab Results.

Finding lab results

In HealthMatics EMR, you can locate lab results multiple ways.

- **Patient chart** - With a patient chart open, click (Lab Results) on the toolbar or left pane. The patient is automatically selected in the Lab Results view.
- **Review Results** - To view results awaiting review, click (Review Results) from the status bar, then double-click a notification message (or select it and click **Open**).
- **Search** - To search for lab results for a patient not on the Lab Results list, from the menu bar, select **Office > Lab Results *or*** on the toolbar or left pane, click (Lab Results) and search for the patient and results.



> Click the **Caregiver** down arrow to select <*All Grantors*> or the caregiver who ordered the lab test.

> At Patient, click (Use Current Chart) ***or*** click the search button (...) to search for a specific patient ***or*** select **All Patients**.

> Click the **Dates** search button (...) to set a date range for the labs you need to view.

NOTE: Selecting **Specific dates** enables the *Specific Dates* fields. Click the down-arrows to select the specific date or range of dates to view.

> Click the **Status** down-arrow and select from *Ordered, Pending, Needs Review, Reviewed* or *All.*

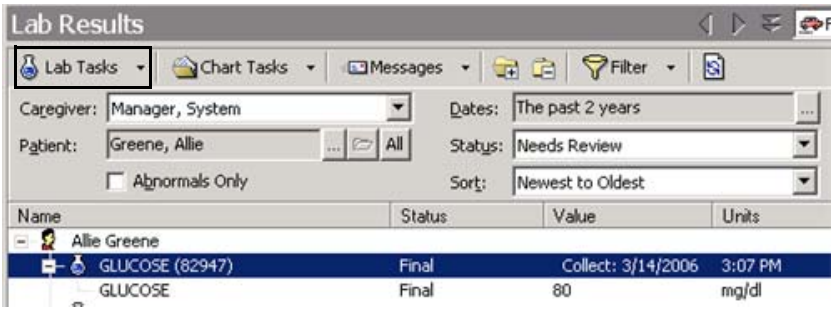
NOTE: You cannot select all statuses if *All Patients* is selected.

> Click the **Sort** down-arrow and select *Oldest to Newest, Newest to Oldest*, or *Alphabetical*.

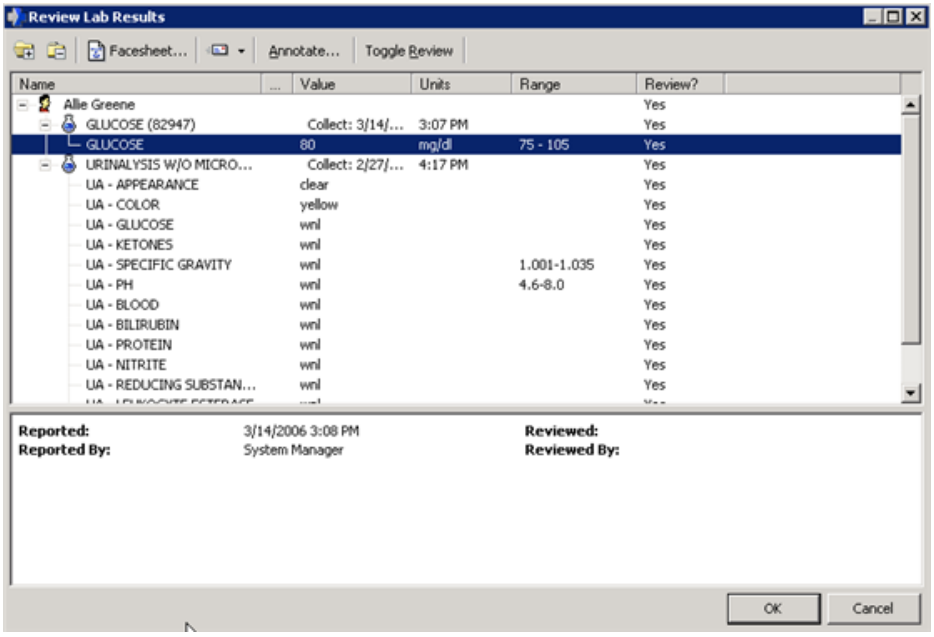
> To view only labs that include abnormal test results, click to select the **Abnormals Only** checkbox.

Annotating lab results during review

1. In HealthMatics EMR, access Review Labs (see Reviewing lab results on page 178 for instructions).

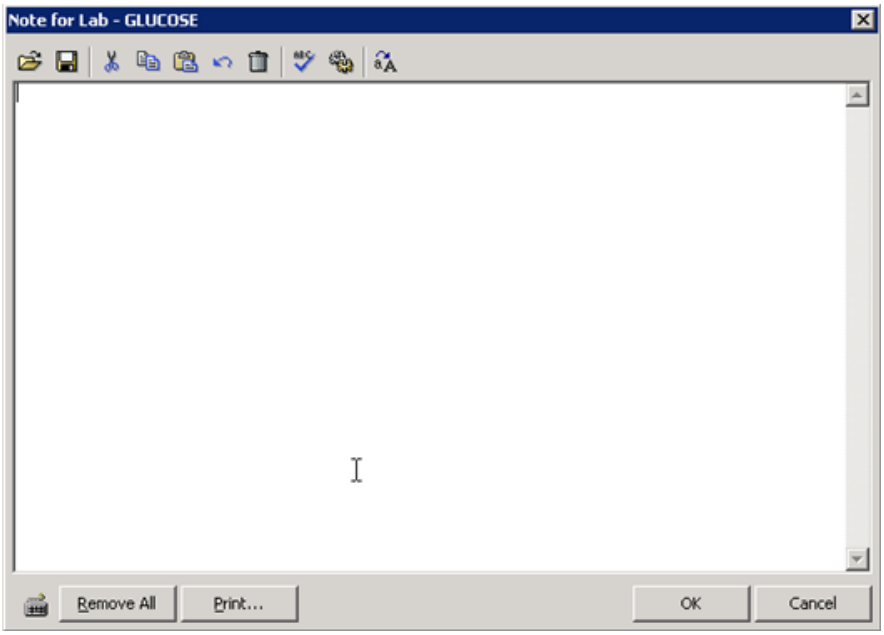


2. From the Lab Results toolbar, click **Lab Tasks > Review Patient**.



3. Select the lab test or result to annotate.

4. From the Review Lab Results toolbar, click **Annotate**.



5. Use conventional word-processing tools or Auto expand text to enter an annotation for the result, then click **OK**.

NOTES
* Annotations display in the bottom pane of the Lab Results screen.

* To remove an annotation from a result **before** the item is marked *Reviewed,* highlight the lab result, click **Annotate** to return to the Note for Lab dialog box; then click **Remove All** and **Yes** to confirm.

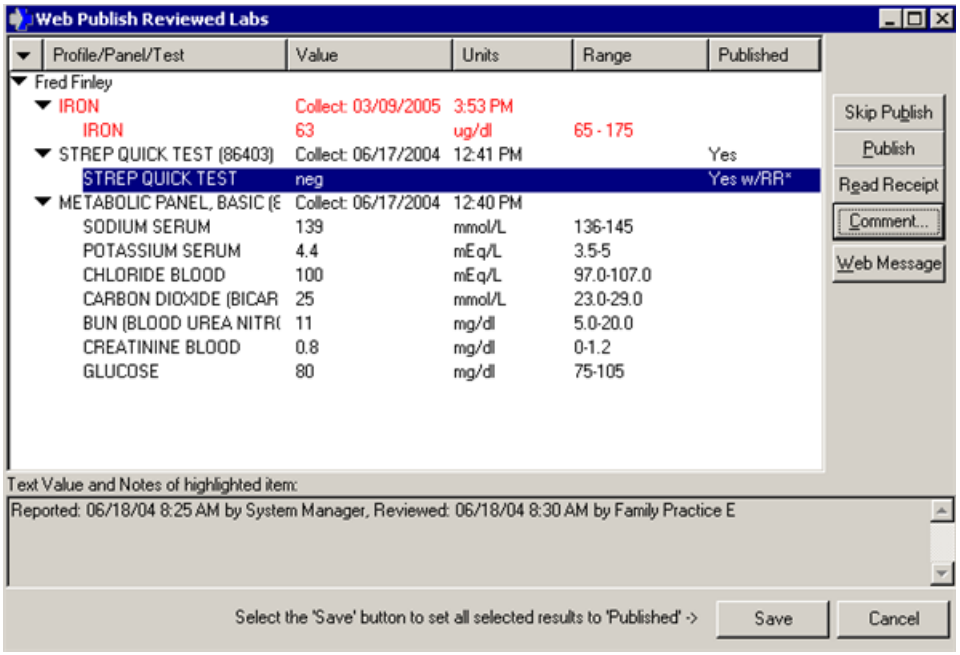
* To print the annotation, click **Print** to select the printer and print properties.

Publishing lab result comments with read receipts

In practices that use HealthMatics Access and publish lab results, you can request Read Receipts so that caregivers are notified when patients open the published results on the Website to see the values. You can also add publishable comments about lab results for patients to view.

1. Open a patient chart, and on the toolbar, click (Lab Results).
2. If necessary, click (Search) to locate the patient, then set *Status* to **Reviewed**.

3. Click **Web Publish** to display Web Publish Reviewed Labs.



4. Select a **result** and click any of the buttons described in the following table.

Button	Action
Skip Publish	Click if you do **not** want the results published on the website.
Publish	Click if you **do** want the results published on the website.
Read Receipt	Click if you want to be notified when the patient opens the test result on the website. *Yes w/RR* displays in the *Published* column. When the patient opens the lab results on the website, an automated message goes to your HealthMatics EMR Inbox automatically.
Comment	Click to attach a comment to results that will be published on the website. Type a comment to attach to the results and select **Read Receipt** if you want to be notified when the patient opens the results.
Web Message	Click to place a message to the patient on the website. The message displays in the *Messages* section of *My Health Portfolio*.

5. Click **OK**.
   Results with comments attached display with an asterisk (*Yes w/RR**) in the *Published* column.

6. Click **Save** to save all published values and comments made to the database.

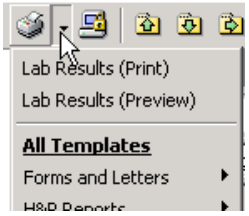
NOTES: The **Web Publish** button is not available if any of the following is true:

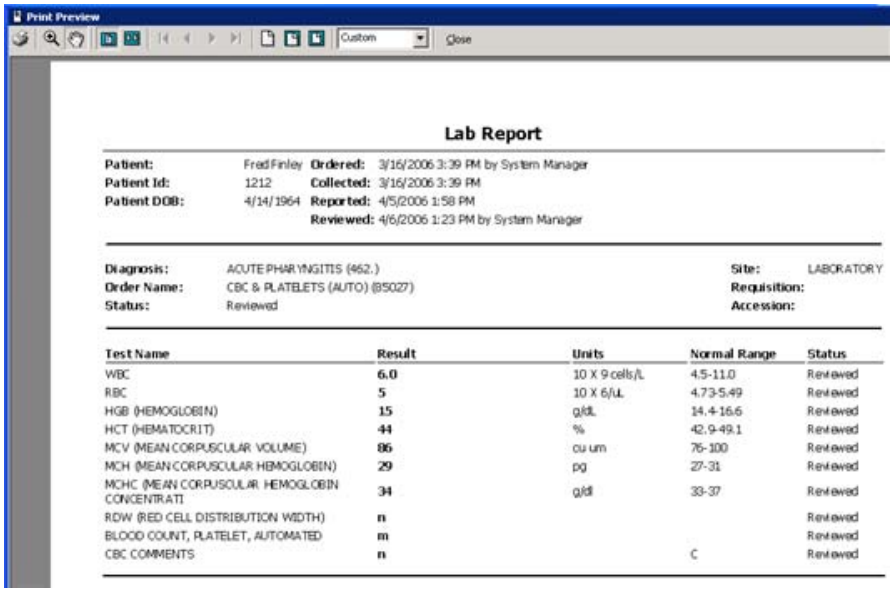
- Your practice is not connected to HealthMatics Access.

- You do not have the security privilege to publish labs, (which is the same as the privilege to review labs).
- You have selected *Show Referrals* on the Lab Results screen.

Emailing/printing lab reports for one patient

1. Open a patient chart, and from the toolbar, click (Lab Results).
2. Select a lab report to print, or to print all lab reports highlight the patient name rather than a specific report. Click the (Print) down-arrow then **Lab Results (Print)** ***or*** to preview the report before printing, click **Lab Results (Preview)**.

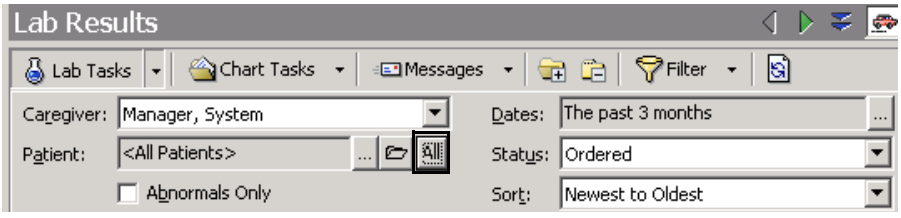



Print Preview
Close
Lab Report
Patient: Fred Finley
Patient Id: 1212
Patient DOB: 4/14/1964
Ordered: 3/16/2006 3:39 PM by System Manager
Collected: 3/16/2006 3:39 PM
Reported: 4/5/2006 1:58 PM
Reviewed: 4/6/2006 1:23 PM by System Manager
Diagnosis: ACUTE PHARYNGITIS (462.)
Order Name: CBC & PLATELETS (AUTO) (85027)
Status: Reviewed
Site: LABORATORY
Requisition:
Accession:
Test Name | Result | Units | Normal Range | Status
WBC | 6.0 | 10 X 9 cells/L | 4.5-11.0 | Reviewed
RBC | 5 | 10 X 6/uL | 4.73-5.49 | Reviewed
HGB (HEMOGLOBIN) | 15 | g/dL | 14.4-16.6 | Reviewed
HCT (HEMATOCRIT) | 44 | % | 42.9-49.1 | Reviewed
MCV (MEAN CORPUSCULAR VOLUME) | 86 | cu um | 76-100 | Reviewed
MCH (MEAN CORPUSCULAR HEMOGLOBIN) | 29 | pg | 27-31 | Reviewed
MCHC (MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATI | 34 | g/dl | 33-37 | Reviewed
RDW (RED CELL DISTRIBUTION WIDTH) | n | | | Reviewed
BLOOD COUNT, PLATELET, AUTOMATED | m | | | Reviewed
CBC COMMENTS | n | | c | Reviewed

3. Click **Close** to exit Print Preview, or to print lab report.

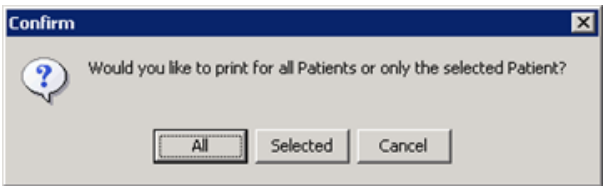
Emailing/printing lab reports for all patients

1. From the toolbar, click (Lab Results).



2. Click **All** in the Patient filter.

3. Select the appropriate *Dates, Status,* and *Sort* to display all patients meeting the selected criteria.
4. Highlight a patient name, then from the Menu bar, click the (Print) down-arrow and **Lab Results (Print)** ***or*** to preview the report before printing, click **Lab Results (Preview)**.



5. Click **All**.
   All results for all patients that meet the selected criteria display consecutively.
6. Click **Close** to exit Print Preview, or to print lab report.

Rules controlling date selections in lab results

When a caregiver leaves the lab results window, the application saves the Results Date Range caregiver option for a single patient or the date range for all patients, whichever was selected.

Routing lab result notifications

The following rules determine how labs and result notifications (messages to provider inboxes) are routed.

- If the order (to which the results belong) is on a requisition, the ordering provider selected on the requisition receives the notification.
- If the order was created by the interface and not on a requisition, the ordering caregiver is used.
- If not on a requisition **and** not received via the interface, the following occurs:
  - > If the scheduled caregiver for the appointment can be determined, that caregiver receives notifications for all labs ordered during the visit.
  - > If the scheduled caregiver cannot be determined, the ordering caregiver is used.
- Caregivers do not receive result notifications if *Block Result Notifications* was checked on the *Caregiver Properties* window in HealthMatics EMR Administration (**Settings > Caregivers > Edit Caregiver Properties**).

Procedure Results

Procedure Results window features are similar to those in Lab Results. You can also send messages about procedure results to caregivers.

You can set performance dates for historical procedures, define procedures as billable or non-billable, enter procedure results, submit procedures to providers for approval, and save them to patient charts.

Defining procedures as billable or non-billable

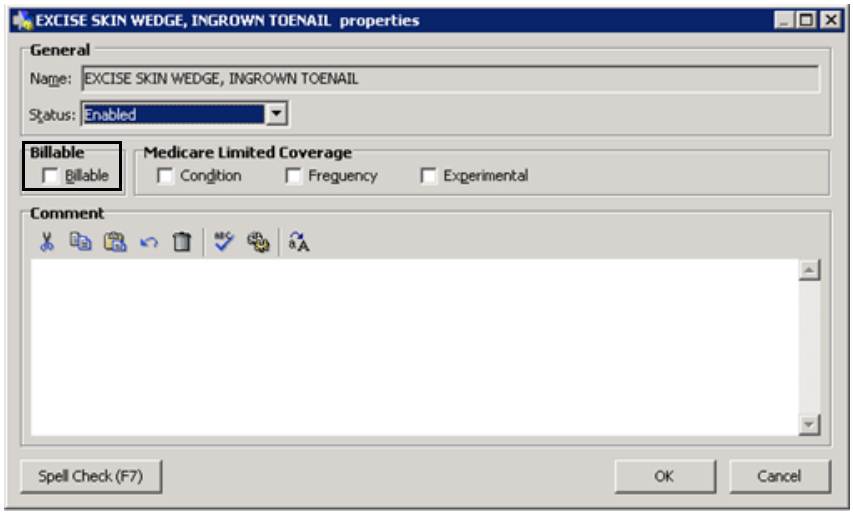
From Assessment/Plan, you can order procedures performed either within or outside your practice. Inside procedures are generally billable, while outside procedures are not. For complete information to create procedure entry rules, see the HealthMatics EMR ***Clinical Customization*** manual.

To mark each procedure billable or non-billable, follow the steps below.

1. From the HealthMatics EMR menu bar, click **Launch > Clinical Customization Module**.
2. Click **(+) Catalogs > Procedure Entry Rules**. Select the procedure and click .
3. Click the **Search** tab then, at *Billing Codes*, select the Procedure Code.

NOTE: A green dollar sign precedes CPT codes that are billable. If the CPT code you are looking for is not on the list, check the Show Archived box. If you still do not find the CPT code, see the HealthMatics EMR ***Clinical Customization*** manual, *How to Create Procedure Entry Rules*.

4. Click .



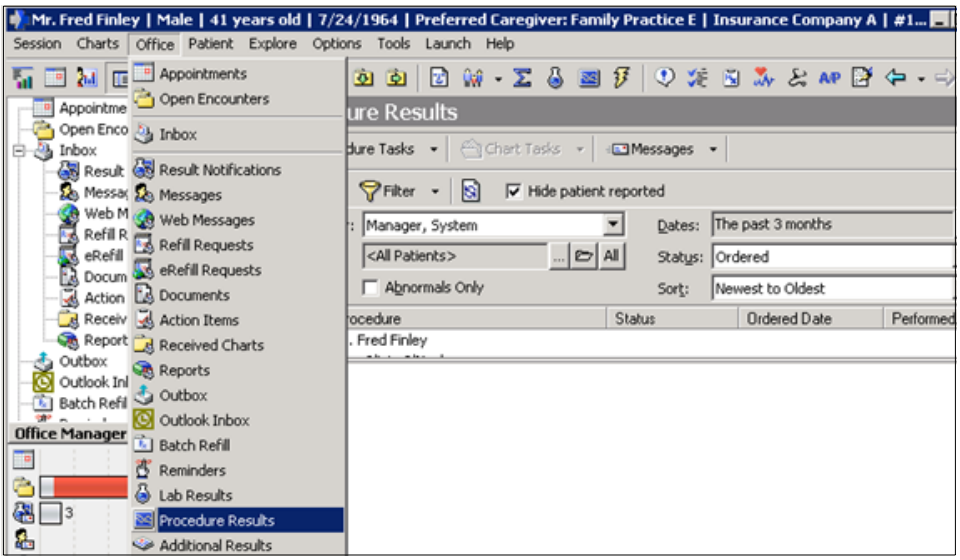
- For procedures that **should be billed** by the practice, click to select the **Billable** checkbox.

- For procedures that **should not be billed** by the practice, the **Billable** checkbox should be left deselected.

5. Click **OK**.

Entering procedure results

1. From the HealthMatics EMR menu bar, select **Office > Procedure Results**, ***or*** with the patient chart open, click (Procedure Results) in the left pane or toolbar.



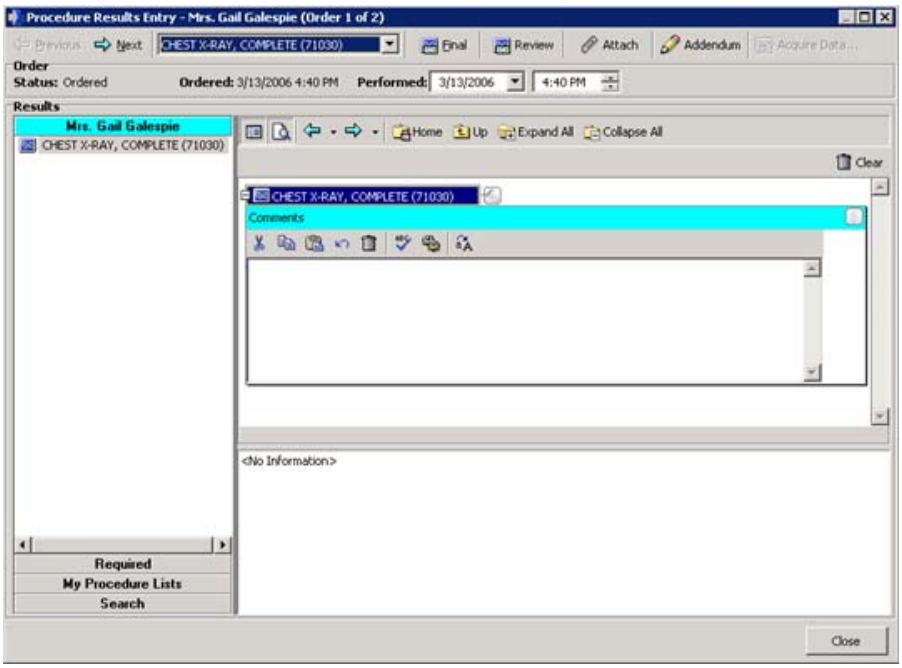
NOTE: The **Office > Procedure Results** delivers all patients with ordered procedures.

2. At *Status*, select *Ordered*.
3. Set other filters as needed (*Caregiver, Patient, Dates, Sort*) to locate the appropriate patient.

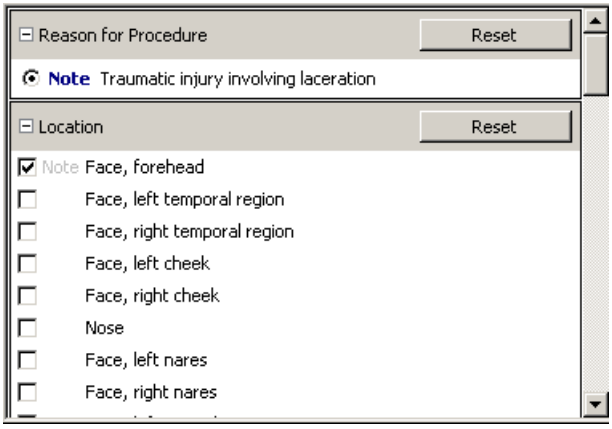
   NOTE: If the patient chart is open on the desktop, at *Patient*, click (Use Current Chart). If not, click the search button ( ) to search for the patient, or for all patients click **All**.

4. Click (**+**) to display patient procedures and select the one you want to enter results for. Details display in the lower pane.

5. On the secondary toolbar (or right-click for a menu), click **Procedure Tasks > Result Entry**.



- If a procedure entry rule was created in **Tools > Edit Procedure Entry Rules**, questions with possible answers display to the right.



  Check boxes and select values to answer questions. The word *Note* displays in gray next to each item as you answer it. You can click it to add a comment.

- For procedures **not** created in **Tools > Edit Procedure Entry Rules**, type or use Auto Expand text to enter the results of the procedure in the text box that displays to the right.
  The word *Note* displays in gray to the right.

6. To enter a free-text note associated with an answer, do the following:

   - Click the word, **Note,** to display Add/Modify note -- Web Page Dialog.
   - Enter text or an image and click **Save**.
     The word *Note* displays in bold in Procedure Results.

NOTES
***** You cannot enter a note after the results are marked *Final*. Instead, click **Addendum.**

***** If you need to change an answer before finalizing it, click **Reset** to clear the fields and start again. For information about changing answers after finalizing them, see Reviewing procedure results on page 191.

7. After all results are entered for a procedure, click **Final**.

   NOTE: A message displays indicating results are ready for review by the provider. The application sends a message that results are ready for review to the caregiver inbox. The caregiver Result Notifications stack and numbers on the inbox and status bar increase by one.

8. Click **OK**.

Reviewing procedure results

When you receive a Result Notification, you can view the results, mark them *Reviewed*, and send messages to other caregivers who may need to review them.

NOTE: Messages sent to other caregivers from Procedure Results do **not** include the results. They are just notifications that results are available for review.

When you receive a Result Notification, review the results accordingly:

1. On the HealthMatics EMR status bar or left pane of the desktop, click (Result Notifications).
2. Double-click a procedure notification message () ***or*** select it and click **Open** to display Procedure Results.

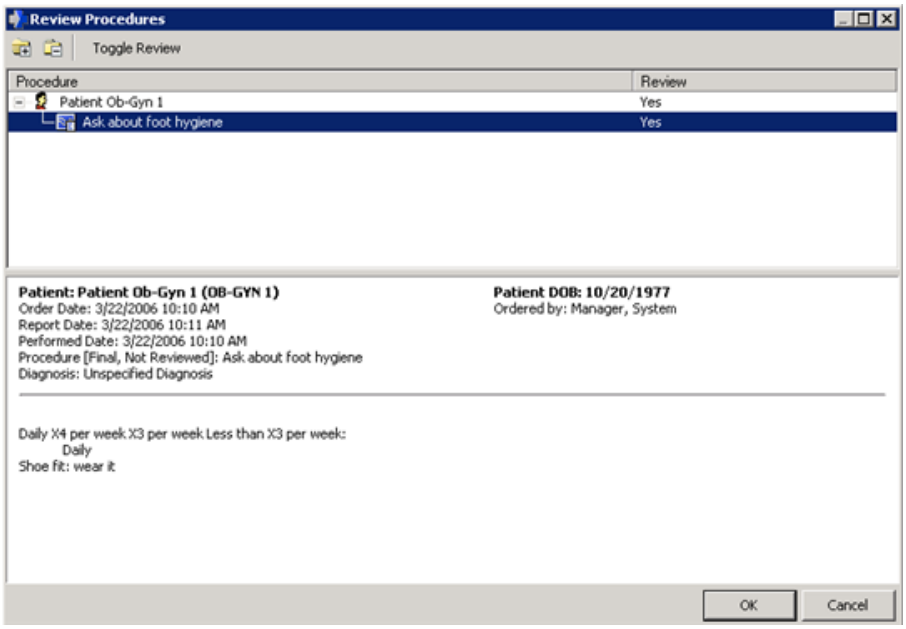
   NOTE: *Status* defaults to *Need Review*.

3. Set filters as needed (*Caregiver, Patient, Dates, Sort*) to locate the appropriate patient.

   NOTE: If the patient chart is open on the desktop, at *Patient*, click (Use Current Chart) ***or*** click the search button () to search for the patient then click **OK**, ***or*** click the **All Patients** checkbox.

4. Click (**+**) to display the patient procedures and values ***or*** click **Expand All**.

5. Select a patient or procedure, and on the secondary toolbar (or right-click for a menu), select **Procedure Tasks > Review All**.



6. Review results by highlighting the procedure and reviewing documentation in the lower window.
7. Procedure results default to Reviewed:
   - Click **Review** or **Review All** (if the patient has multiple test results).
   - Click **OK**.
     The *Status* of the procedure results changes to *Final, Reviewed* and can no longer be changed. However, you can add Entry Error notes, if needed.
8. Click **OK** to exit and save.
9. **Use chart tasks to do the following:**
   - **To attach results** to the patient chart, click **Chart Tasks > Attach to Chart**, select the original, current or both encounter(s) to attach it to, then click **OK**.
   - Pull the Chart.
   - View the Face Sheet.
   - Attach results to an encounter.

     NOTE: Procedure results appear as attachments in the *Encounter* pane of the patient face sheet.
   - **To view the patient face sheet**, click **Face Sheet > Chart Tasks**.
     Click **Close** to return to Procedure Results.
   - **To pull the patient chart**, click **Pull Chart**.

     NOTE: Pulling a patient chart takes you out of Procedure Results.

10. **Use messages to do the following:**

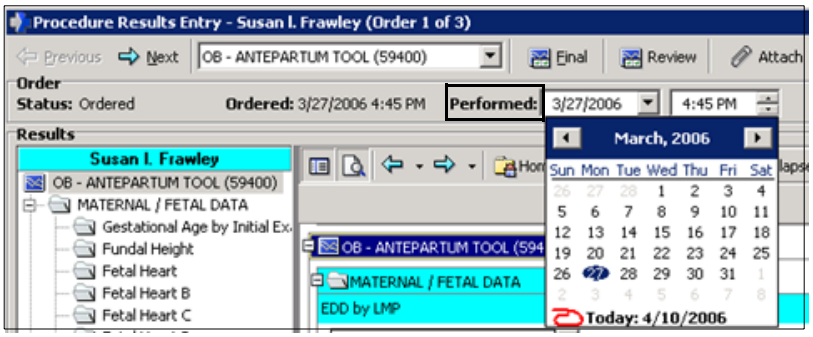
    - **To send a message** to another caregiver about the results, click **Messages > Send Patient Message**.
      Create and send the message as you would any Patient Message.
      See Sending patient messages on page 39.

      NOTE: The application does **not** attach the procedure results to these messages.

    - Send a Web message.

    - **To print results**, click **Print > Procedure Results**. The results print automatically.

    - **To set the date** the procedure was performed (for historical procedures), select the correct date when entering the results by clicking the drop-down arrow to display a calendar. See Setting performance dates for historical procedures on page 194.



    - **To bring in procedure result data** over an interface (such as MidMark, if you purchased and connected it), click Procedure Tasks > Acquire data from.

Viewing final, not reviewed procedure results

In HealthMatics EMR, if procedure results were entered and marked *Final*, but were not reviewed by the caregiver, you can locate them in the following places:

- From the *Orders* pane of the patient face sheet, double-click the order ***or*** select the order and click **View**.
- From the desktop, click (Result Notifications) in the inbox or the stack.
- From the status bar in any view, click (Result Notifications).
- Go to the Procedure Results screen and choose *All patients*, *Needs Review* (set other filters as desired).

Viewing final, reviewed procedure results

If procedure results are finalized and marked *Reviewed* by the caregiver, you can locate them in the following places:

- From the *Orders* pane of the patient face sheet, double-click the order ***or*** select it and click (View).

- From the left pane or toolbar, click (Procedure Results), click the **Status** down-arrow and select **Reviewed**.
- Set the remaining filters (*Caregiver, Patient, Dates, Sort*) as needed to locate the patient.
- Click (**+**) or Expand all to view the tests. Select the test to view the values.

Setting performance dates for historical procedures

To enter historical procedures (those ordered on one date and scheduled for a future date or those ordered on one date but performed previously, “order” the historical procedure(s) in **Assessment/Plan**. Set the performance dates in Procedure Results to reflect the date the procedure was actually performed.

1. With a patient chart open in HealthMatics EMR, from the toolbar or left pane, click ***or*** from the menu bar, select **Office > Procedure Results**.
2. Accept the current patient ***or*** click the **Patient** search button ( ) to search for, and select the correct patient.
3. Click the **Status** down-arrow and select **Ordered**.

   NOTE: Performance dates cannot be changed once the procedure is marked *Reviewed*.
4. Set the remaining filters (*Caregiver, Dates, Sort*) as needed to locate the patient with historical procedures entered.
5. Click the (**+**) in front of the name (or click **Expand All**) to display the procedures.
6. Select a procedure and click **Procedure Tasks > Results Entry**, then click the *Performance* down-arrow to display a calendar.
7. Select a date from the calendar and set the time the procedure was performed, then click **Close**.
   On the patient face sheet, the Order History details reflect the accurate *Performed date*.

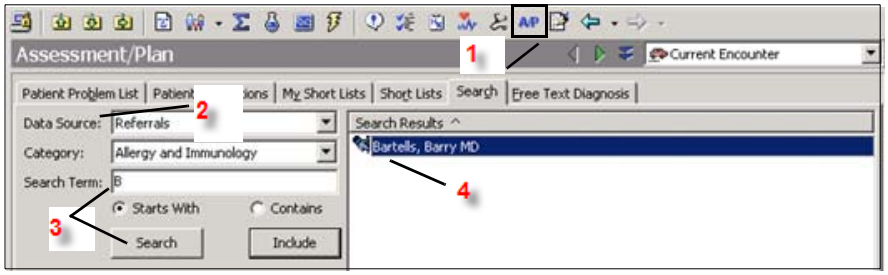
NOTE: You can change performance dates only on procedures not linked to an external source such as a Brentwood device.

Additional Results

The Additional Results folder contains orders other than labs or procedures such as referral letters and their responses and other authored text items.

Processing referrals

Order referrals in *Assessment/Plan* (steps 1-4 on the graphic).



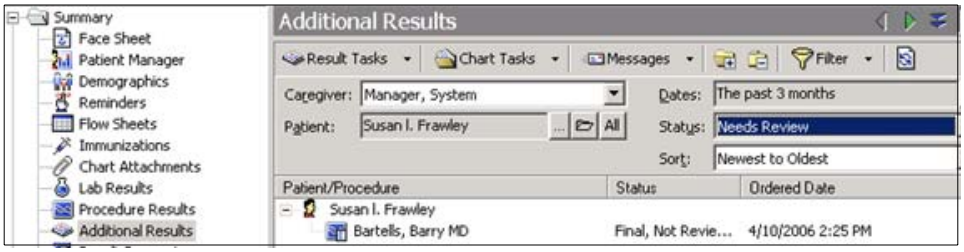
NOTE: For detailed instructions for ordering referrals, see Documenting referrals on page 311.

Then enter responses from referring caregivers in the Additional Results view.

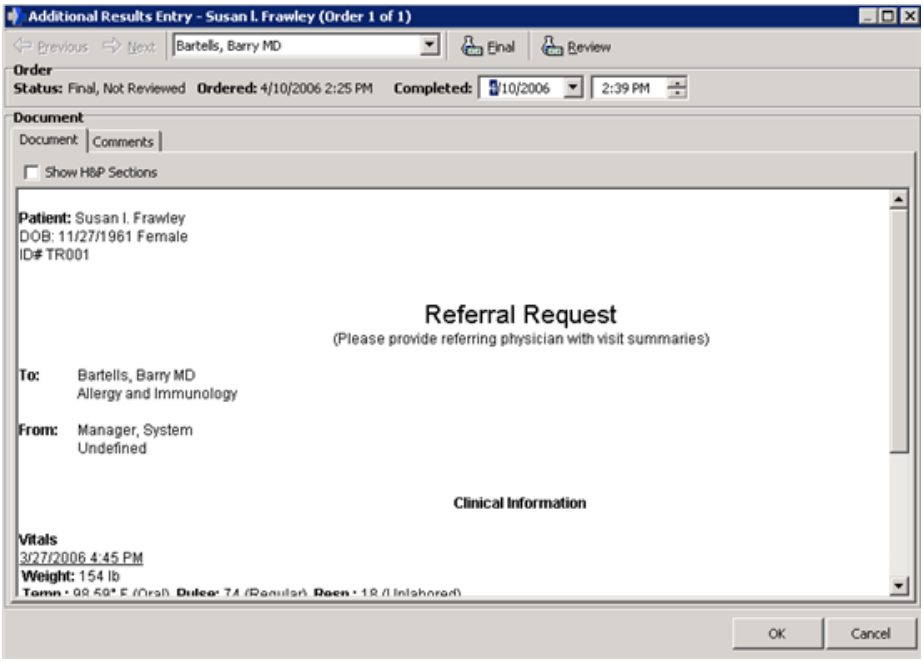
To access referral results

When referral results are received from the referral physician, enter and mark them Reviewed in Additional Results.

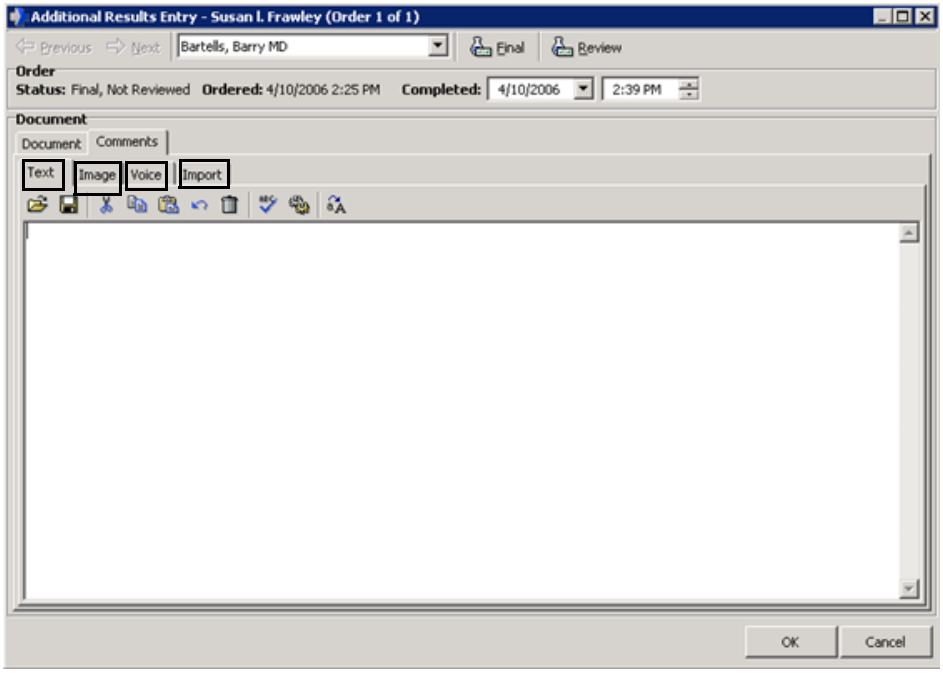
1. From the HealthMatics EMR menu bar, click **Patient > Additional Results *or* Office > Additional Results *or*** from the left navigation pane, click Additional Results (Additional Results).
2. Click the *Status* down-arrow and select **Ordered**.



3. To enter results, select the referral procedure, then click **Result Tasks > Result Entry**.



4. To enter comments, click the **Comments** tab.



5. You can enter text, image, voice, or import referral results on each specific tab.

NOTES

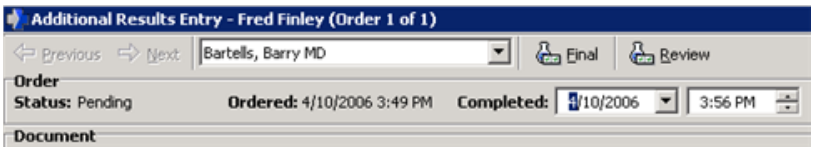
* Use conventional word-processing tools to add text comments.
* Use **Image** to add anatomical images.
* Use **Voice** to enter a voice note.

* Use **Import** to import a file or report.
* Click (Save image to a file) to save the file so it is accessible from your workstation outside of the EMR.

6. At *Completed*, accept the default date or change it to the date the results were entered.
7. When you are finished, click **Final** to save the results.
8. Click **OK** to save the referral results and return to Additional Results.

To review final referral results

1. Access Additional Results (see To access referral results on page 195).
2. At *Status*, click down-arrow and select **Needs Review**.
3. Click **Review All**.



All results needing review default to a status of Reviewed.

4. Select a referral result and click **Toggle Review** to deselect any referrals.
5. Click **OK**.
6. **To print additional results** select the Patient and/or the item and from the HealthMatics EMR menu bar, click **Print > Additional Results**.
The results print instantly.

Processing authored text

Patient Education, Office Procedures, Discharge Plans and Nursing Services can contain authored text that will require review or follow-up.

1. Access *Additional Results* (see To access referral results on page 195).
2. Choose the *Ordered* status and set other filters as desired.
3. Click **(+)** or **Expand All** to view items.
4. Select the authored text and Right-click or click **Result Tasks** and choose the needed action:
   - **Review all** - Launches the Review screen allowing you to review all finalized results.
   - **Finalizes** - Finalizes the result without entry of additional comments.

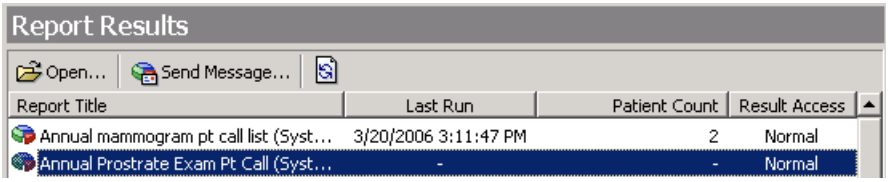
     NOTE: You can customize authored text so it is automatically finalized when ordered.
   - **Result entry** - Launches the dialog box allowing entry of additional comments.

NOTE: You can mark the result *Final* and *Reviewed* from this screen (see To review final referral results on page 197).

Report Results

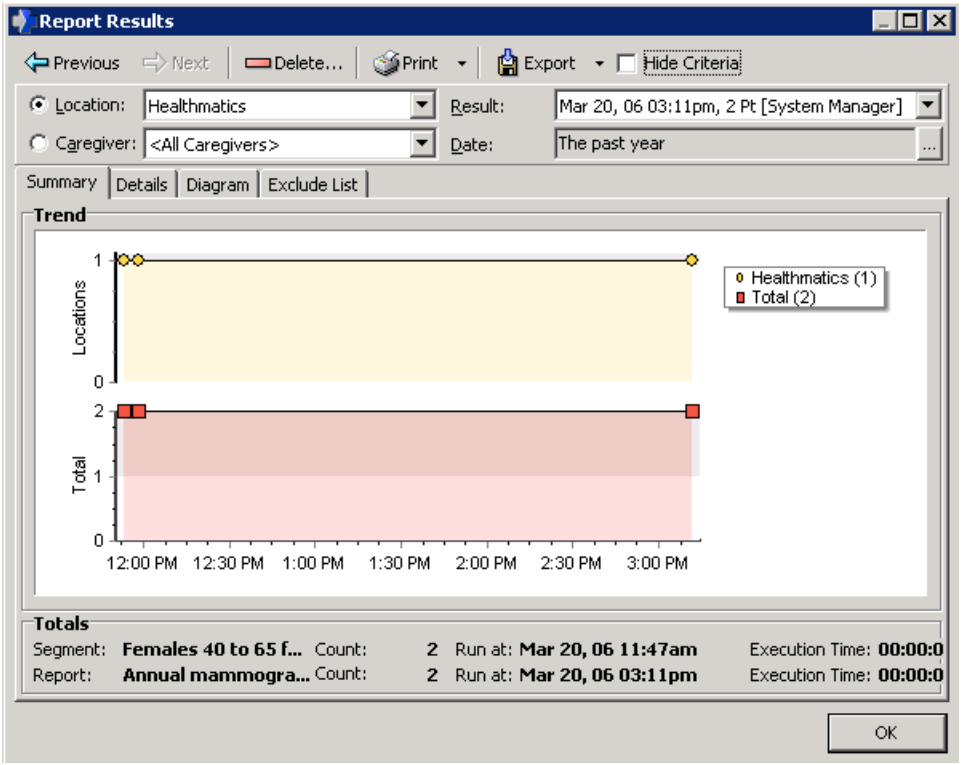
The Report Results view lists all reports that were created in the Reporting Module, the last run time, and the number of patients who met the search criteria when the report was last run. You can open a report in the Clinical Module to view the details.

1. To access *Report Results*, from the left pane on the desktop ***or*** from the **Office** menu, select Report Results.



NOTE: Access to open report results can be restricted in **Administration Module > Function Access**. To restrict viewing, when building the report in the **Reporting Module > Report Properties**, check the **Restricted Access** box. For detailed instructions, refer to the ***Reporting Module*** manual.

2. Select a report with Result Access Normal (or Restricted if you have the appropriate privilege) and click **Open *or*** just double-click the report.



3. For a detailed description of the Report Results screen, refer to *Viewing Report Results* in the ***Reporting Module*** manual.

Result Summaries

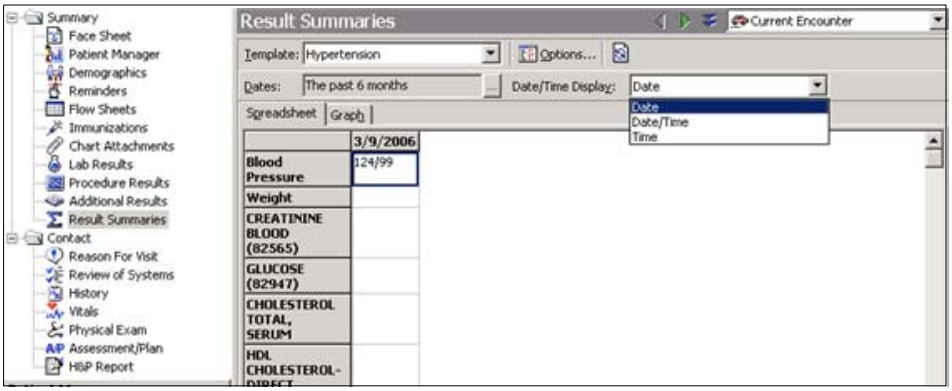
Result Summaries allow tracking of patient data over time. Use HealthMatics EMR flow sheets to create spreadsheets and enter data manually. Use Result Summary templates to automatically extract and pull together result data entered elsewhere in HealthMatics EMR into a spreadsheet or graph format.Choose from CPT, HCPCS, Procedure Entry Rules, Laboratories, Medicines, Physical Exam elements, and Vital Signs.

NOTE: Imported information can include data from internal laboratory tests as well as results transmitted from external labs **IF** the external labs are cross-referenced to the CPT codes in the HealthMatics EMR Lab Catalog. (See the HealthMatics EMR ***Clinical Customization*** manual to set up Result Summary templates.)

Viewing result summaries

The default Result Summary display is spreadsheet format. You can also choose to display data in graph format by clicking the **Graph** tab.

1. With a patient chart open in HealthMatics EMR and from the Menu bar, select **Patient > Result Summaries *or*** from the left pane or toolbar, click Σ (Result Summaries).

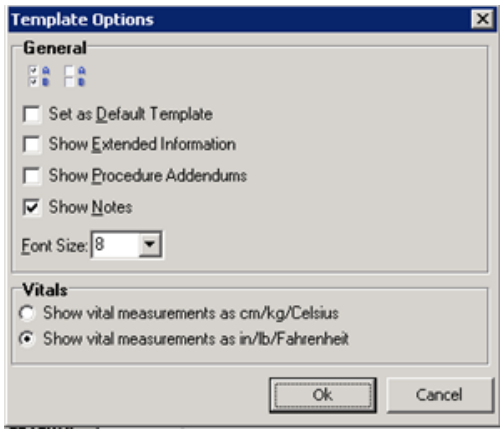


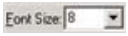
2. Click the **Template** down-arrow and select a template from the list. If data is available, the screen populates in spreadsheet format. If data is not available, a message displays *"No data to display."*

3. View data using either the *SpreadSheet* or *Graph* tab.

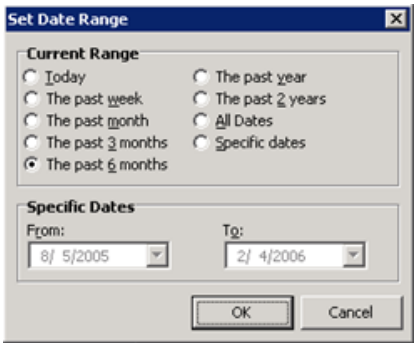
Tab	Description
Spreadsheet	Displays data in rows and columns.
Graph	Displays selected data in line graphs.

4. **(Optional)** For template options, click **Options**.



Template Options	Action
	Select all template options.
	Deselect all template options.
Set as Default Template	Click checkbox to make the spreadsheet tab template the default caregiver view to remain in effect until changed.
Show Extended Information	Click checkbox to include the order date, name of the result, units of measure along with the results, in the template.
Show Procedure Addendums	Click checkbox to include additional procedure information.
Show Notes	Click checkbox to include notes in view.
	Click down-arrow to choose the font size (8 -15 pts) for the view.
Show vital measurements as cm/ kg/Celsius	Click radio button to display measurements in metric units.
Show vital measurements as in/lb/ Fahrenheit	Click radio button to display measurements in non-metric units.

5. To change **Dates** view, click (Ellipsis Search button) and select a date range for encounter dates to include in your result summary.



Current Range	Action
Radio button choices	Click one radio button to select a current date range.
or	
Specific Dates	Enter the *From* and *To* dates in *m/d/yyyy* format, ***or*** Click the down-arrow to select dates from a calendar.

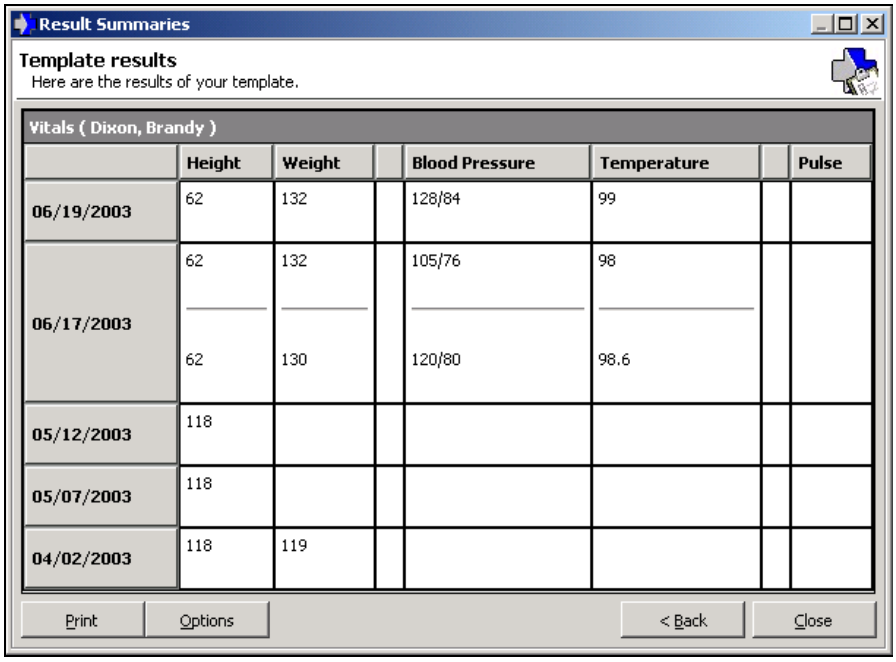
- Click **OK** to return to Result Summaries.

6. At *Date/Time Display*, select how you want to display date and time.

Option	Action
Date	Date displays in *m/d/yyyy*
Date/Time	Date/time displays in *m/d/yyyy h:mm PM* format
Time	Time displays in *h:mm PM* format

7. Click **OK**.

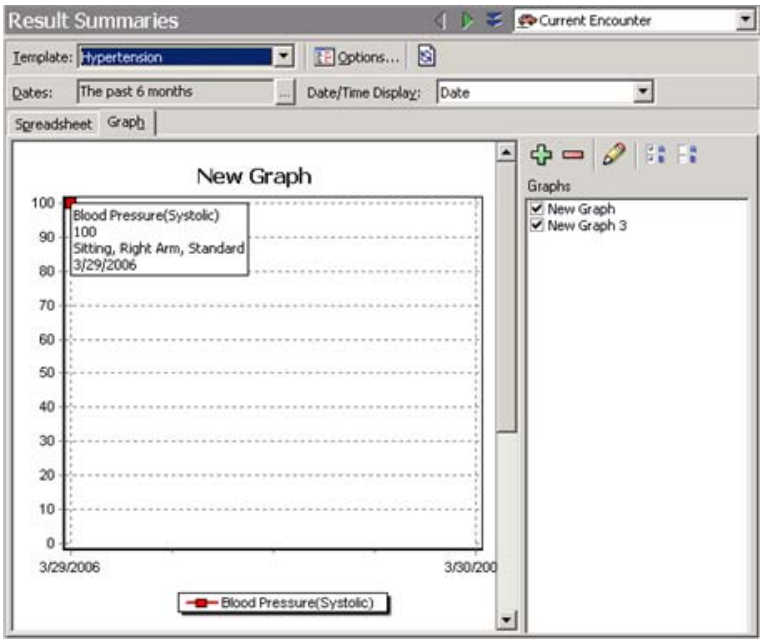
To view spreadsheets - default view



- To change the appearance of the spreadsheet, click **Options** to display Template Options. (See Viewing result summaries on page 199 for information about the options available.)
- Click **Print > Result Summaries** to print the spreadsheet.
  The Print dialog box displays. Select the Printer, Paper Orientation and whether you want to print a spreadsheet or graph.
- Click **OK** to print.

To view graphs

Click the **Graph** tab for the selected template to select items you need to view in graphical format. Previously created graphs will be available for view.



Creating new result summary graphs

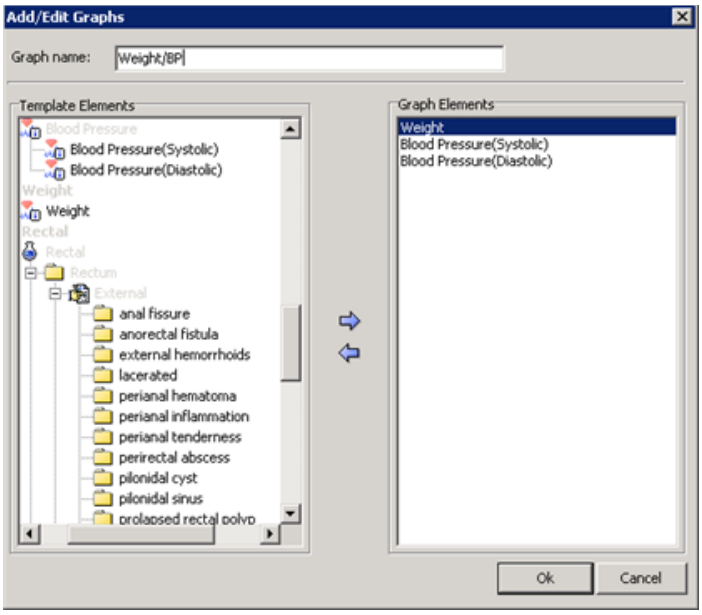
To create a new graph to view patient data, do the following:

1. With a patient chart open in HealthMatics EMR, from the left panel, click Σ.
2. Select a template.
3. Click the *Graph* tab to create/add the graph format.
4. From the Graph toolbar, click ✚.

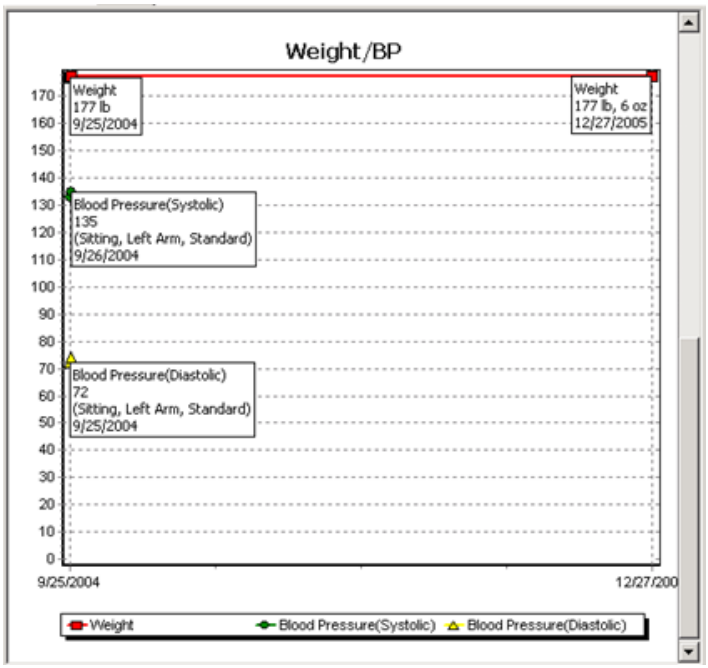
5. At *Graph name*, enter a unique, new graph name.
6. Double-click to choose Template *Elements* you want or highlight and click ➪ to add your selection to *Graph Elements* up to 15 max.)

- To remove a Graph Element, select it then click ⇦.

NOTE: Non-numeric items cannot be added to a graph.

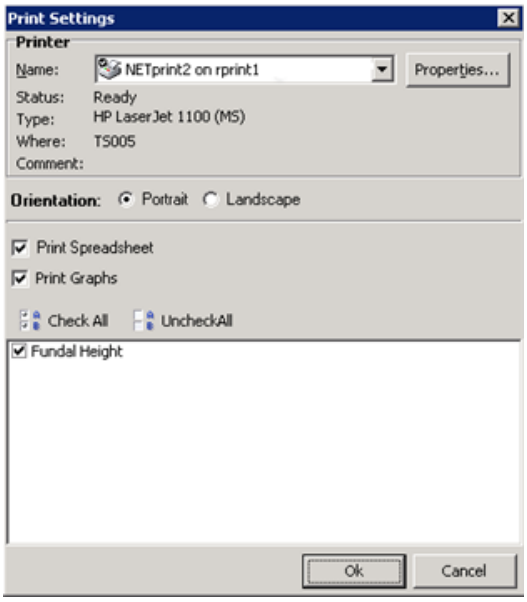


7. Click **OK**.To create another graph, click **New Graph** again and repeat steps above.



8. To display data point details, click the data point.

9. To print, from the HealthMatics EMR toolbar, click , then **Results Summary**. Select the print options.



10. Click to return to the patient Face Sheet, or click **Back** to return to the previous screen.

NOTES

- Graph title names display above each graph.
  A legend displays at the bottom of each graph.
- If more than one graph is created, scroll down to see additional graphs.
- Each data element is color-coded and indicated by a different shape.
- To view specific information about a particular data point, click the point to see extended result information. Click again to hide the data.
- Only graph elements that contain data display.
- Graphs save automatically to the *Graphs* list box in the far right pane.

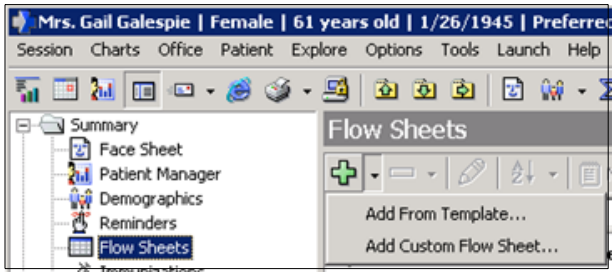
Flow Sheets

Use Flow Sheets to manually enter data in spreadsheet format to the patient record.

To add flow sheets

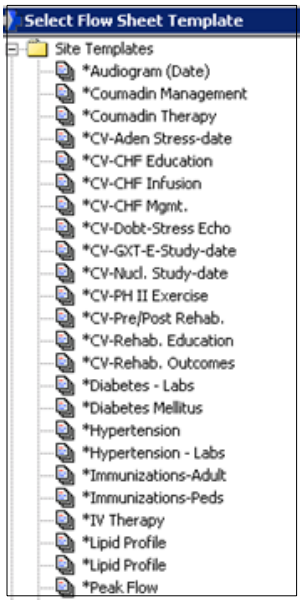
1. Open a patient chart, and access flow sheets:
   - From the menu bar, select **Patient > Flow Sheets *or***
   - From the toolbar, click the down-arrow and select **Flow Sheets *or***
   - From the left pane, click **Flow Sheets**.

2. Click .



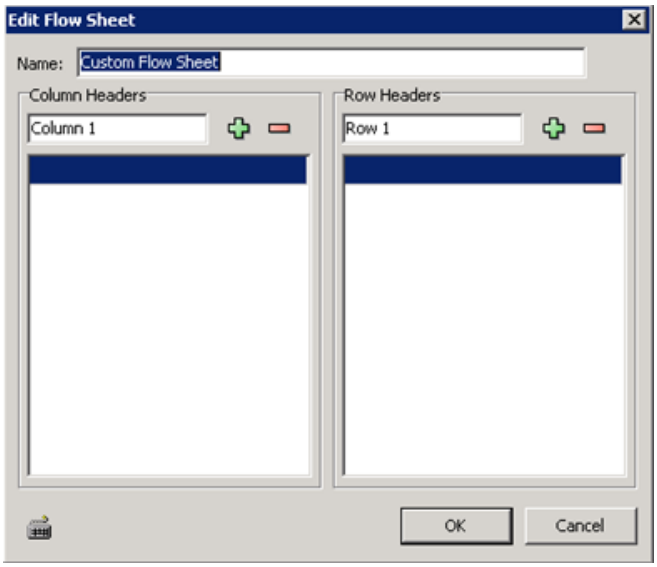
Select either:

Add From Template - Add a Flow Sheet from a template either delivered with the application or created in the **Customization Module**,



or

Add Custom Flow Sheet - Add a custom Flow Sheet for this patient only.



3. **IF** using a prepared template, select a Flow Sheet template from the list, ***or***
   IF adding a new, custom Flow Sheet, enter a name for the new Flow Sheet and column and row headings, clicking ✚ after each entry.
4. Edit the Flow Sheet template or custom template column and row headings as needed.
5. Click **OK** to save the Flow Sheet to the chart and begin manual entry of data.

NOTE: A flow sheet cell that contains data becomes a locked cell after the encounter is signed off. However, you can strike through a locked cell and create a new row or column with the correct information.

To correct erroneous entries on flow sheets

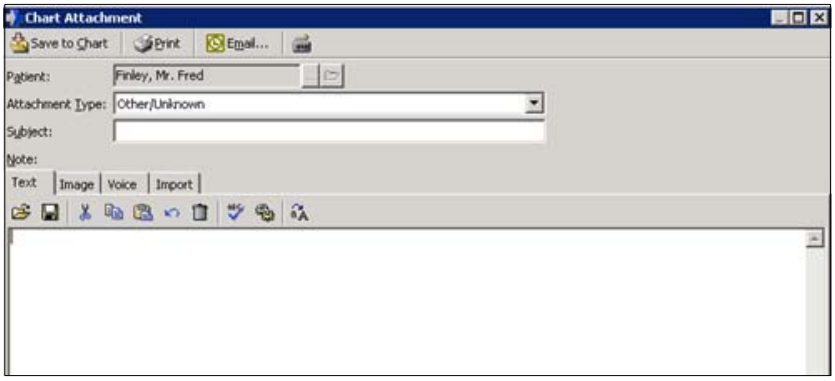
1. Access Flow Sheets.
   (See To add flow sheets on page 206.)
2. Click the **Flow Sheet** down-arrow and select the flow sheet to correct.
3. Click the cell containing the data for change.
4. Click Erroneous.
   The entry changes to gray font and strikes a line through erroneous text.
5. Click **Edit**.
6. Enter a new column or row heading and click ✚.
7. Click **OK**.
8. Enter the corrected data in the appropriate cell.
9. Click and drag the new column or row to the appropriate position in the flow sheet.

Chart Attachments

You can add attachments such as copies of letters, EKG reports, and laboratory reports to an encounter. The attachments can be viewed from the patient face sheet, either in an attachments folder or from an H&P Report if you attached them to an office visit.

Adding chart attachments

1. Open a patient chart, and do one of the following:
   - From the menu bar, select **Patient > Chart Attachments** ***or***
   - From the toolbar, click the Demographics down-arrow and select **Chart Attachments** to display Chart Attachments.
2. From your keyboard, press **Insert** ***or*** click (Add Attachment).

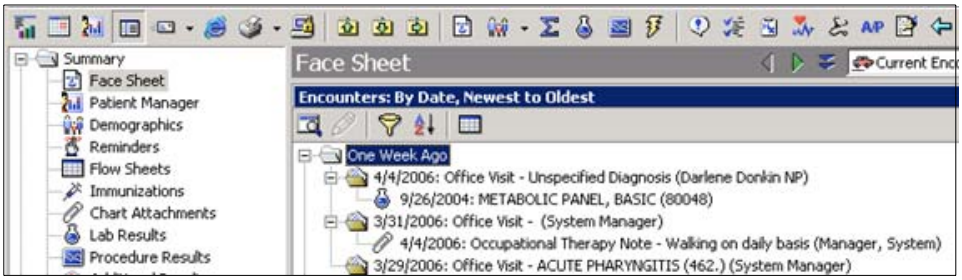


3. Click the **Attachment Type** down-arrow and select the Attachment Type from the drop-down list.

   NOTE: Types can be added in the **Administration Module > Dictionary**.
4. At *Subject*, enter a subject for the attachment.
5. Select a tab to enter text, upload an image, dictate a voice note, or import a file as needed.
   - To attach a document from a file, from the **Text** tab, click (Load from File).
   - To attach an image from a library, on the **Image** tab, click (Load Image from Library).
6. Use the Chart Attachment toolbar icons to do any of the following:
   - **To save to chart**, click **Save to Chart**
   - **To preview/print**, click (Print Chart Attachment).
   - **To email**, click (Email Chart Attachment).
7. Click **X** in the upper right corner to close window.

Linking chart attachments to office visits

1. With the patient chart open in HealthMatics EMR, from the left pane ***or*** the toolbar, click (Face Sheet).
2. If encounters are not already sorted by date, click (Toggle Filter) to sort the encounter *By Date*.
3. Click on the Encounters title bar to maximize the pane.



4. Locate both the attachment and the office visit you want to link it to.
5. Click and drag the attachment (with the paper clip) to the appropriate office visit. The attachment can now be viewed from the H&P Report (see Viewing chart attachments from face sheet on page 210).

Viewing chart attachments from face sheet

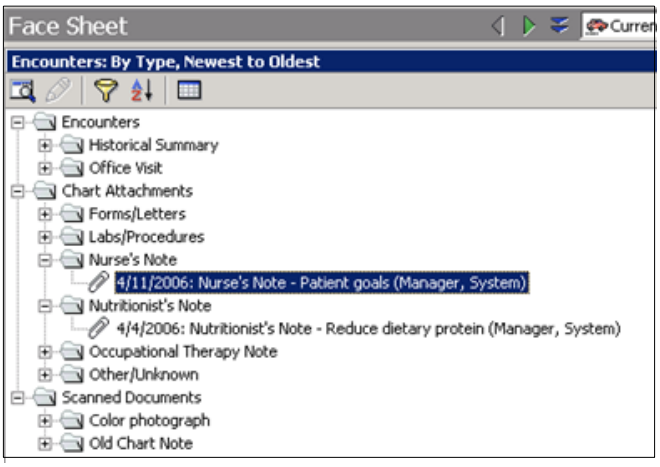
There are two ways to view chart attachments from patient face sheets. With a patient chart open in HealthMatics EMR, from the left pane ***or*** the toolbar, click (Face Sheet).

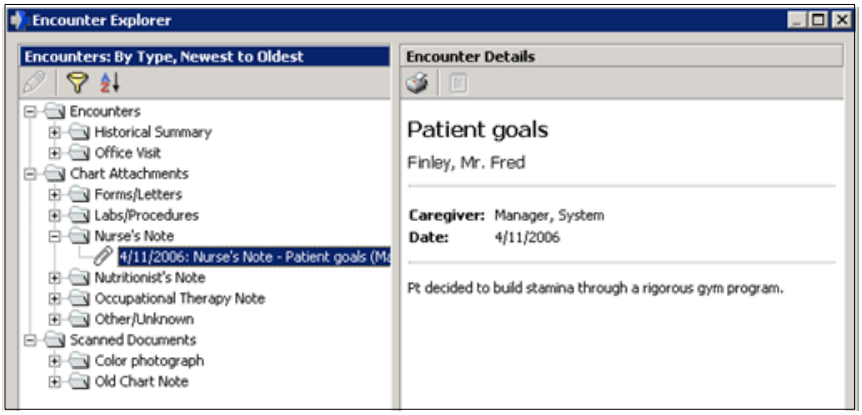
- **By type** - Click (Toggle Filter) on the *Encounters* pane title bar to sort the encounters *By Type*.

  > Click on the Encounters pane to maximize the pane.

  > Click (**+**) to open **Chart Attachments** and other folders, as needed, to locate the attachment ( ) you want to view.

  > Select the attachment, then double-click it or click (View Encounter).





Click **X** in the right upper corner to exit screen.

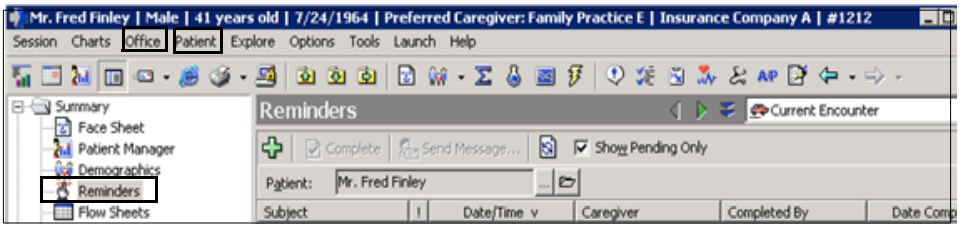
Reminders

If a reminder is placed on a patient chart, it can be set to display immediately whenever the chart is pulled, or alternatively, on the start date of the reminder as long as it remains active.

NOTE: Reminders become a permanent part of a patient record. Once created, reminders cannot be changed or deleted (although they can be marked “done”).

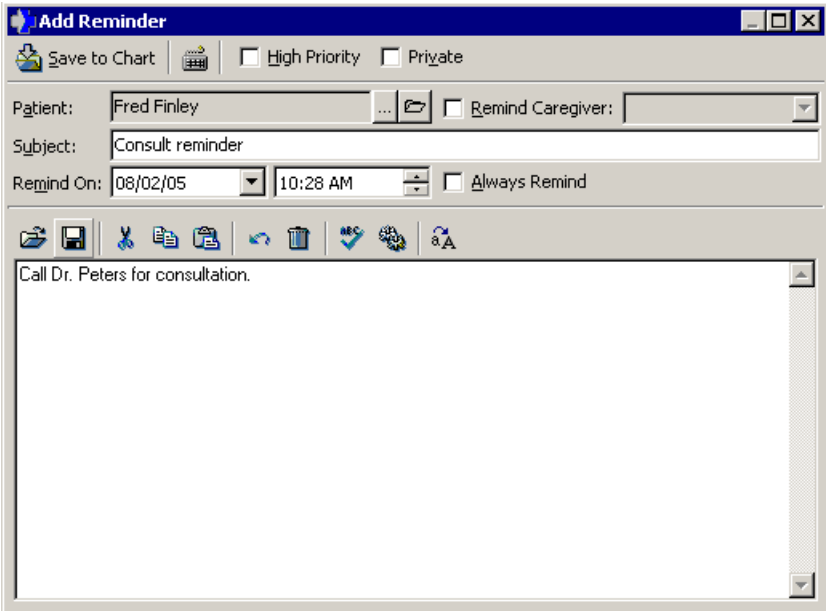
Creating reminders on patient charts

1. With a patient chart open, from the HealthMatics EMR Menu bar, click **Patient > Reminders** or **Office > Reminders** or click **Reminder** on the left navigation panel.



   To view only pending reminders, click the Show Pending Only checkbox.

2. Click ✚.



3. Select checkboxes if desired:
   - **High priority** - Click to make the reminder display in red.
   - **Private** - Click to make the reminder visible only to the user who created it.
4. At *Patient*, do **one** of the following:
   - To place the reminder on the current open chart, click 🗁 ***or***

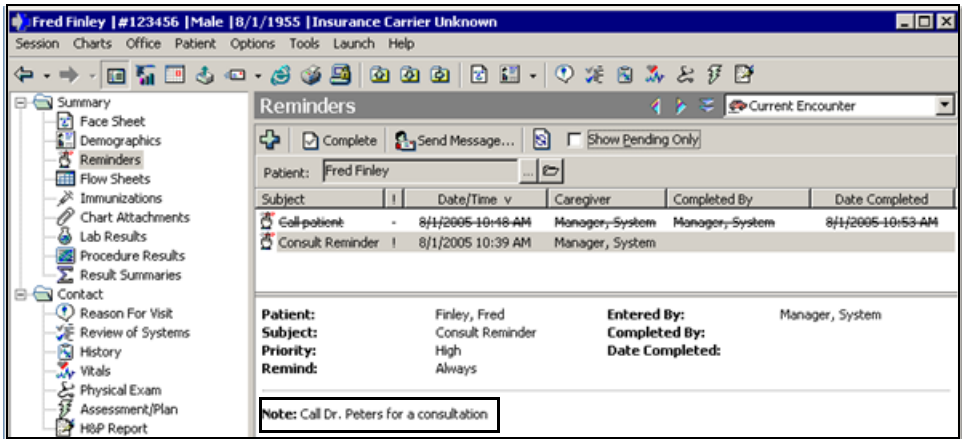
- To place the reminder on another patient chart, click ... and search for the patient.

5. At *Remind Caregiver*, do **one** of the following:
   - **To remind one** caregiver only, select the box and click the down-arrow to select the caregiver to receive the reminder ***or***
   - **To remind all** caregivers, deselect the *Remind Caregiver* box.
6. At *Subject*, enter a description for the reminder.
7. At *Remind On*, do **one** of the following:
   - To create a reminder that displays every time the patient chart is pulled, select **Always Remind**.
   - To create a reminder for a specific date/time, deselect *Always Remind* and click the date and time arrows to select the *Date* and *Time* you want the caregiver to receive the reminder. An Action Item displays on the caregiver desktop at the designated date and time.

     NOTE: You can also type the date/time in the respective fields.
8. Type the reminder text in the text box.
9. Click **Save to Chart**.

Viewing and completing reminders

1. With a patient chart open, from the HealthMatics EMR Menu bar, click **Patient > Reminders**, **Office > Reminders, *or*** from the left navigation panel, click **Reminders**.



   NOTE: To hide completed reminders, click **Show Pending Only**.
2. Select the reminder to display reminder text in the pane below.
3. To send the reminder to another caregiver, click **Send Message**, and complete the Patient Message dialog box (see Sending patient messages on page 39).
4. To inactivate the reminder, click **Complete**.
   The reminder displays grayed out with a line through it, and the name of the user

who marked the item “Complete” displays in the *Completed By* column and the date the item was marked done displays in the *Date Completed* column.

NOTES

- Reminders are permanent entries in patient charts and cannot be deleted.
- Reminders can also be completed from the Action Items view (see Responding to patient messages on page 40).

Lab Order Entry

Use Lab Order Entry to manage lab orders, create requisitions, and send lab orders for lab tests and panels from HealthMatics EMR. If your lab supports bi-directional interfacing, you can generate lab requisition forms directly from HealthMatics EMR to external laboratories for processing. If you purchased a lab interface, you can electronically receive lab results from a lab directly into the patient chart.

Requisitions can contain one or many lab orders, depending on laboratory preference. You can create a requisition for all orders within an encounter or for just one lab test either on the A/P screen or in Lab Order Entry.

You can define all items you need in your database to send or print requisitions electronically using Lab Order Entry Setup in the Clinical Customization Module. The Clinical Customization Module stores all information needed to generate lab requisitions including practice information, patient information, and external lab ID codes that may be required by insurance carriers. You can set up priority statuses for lab orders and define specimen containers, sites, and sources. You can also create Selection Lists for easy entry of lab results. (See the HealthMatics EMR ***Clinical Customization*** manual for detailed Lab Order Entry setup information.)

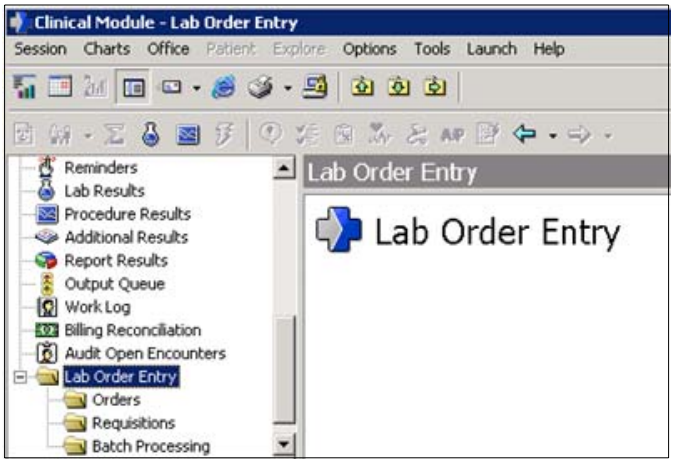
From Lab Order Entry, view tests and panels ordered in Assessment/Plan. You can generate printed requisitions and labels for specimens.

Lab Order Entry includes the following:

- **Orders** - Each single-result test or panel result lab is considered one lab order.
- **Requisitions** - A requisition is an electronic form documenting a group of lab orders for one patient and may be associated with specimens.
- **Batch Processing** - Requisitions grouped together in a printable format processed in a batch. Requisitions can be electronically transmitted from this screen.

Accessing lab order entry

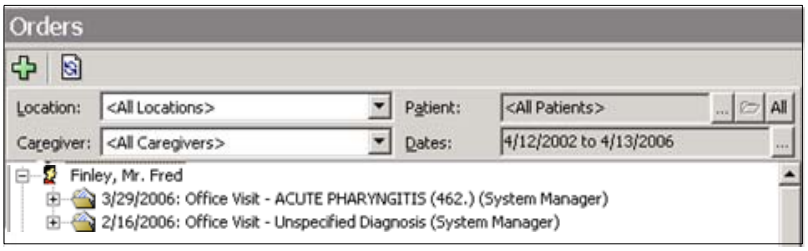
1. From the HealthMatics EMR left navigation panel, click **(+)Lab Order Entry** to expand the folder.



2. Click the subfolder required.

Viewing lab orders

1. Access Lab Order Entry (see Accessing lab order entry on page 214).
2. Click **Orders**.



Field/Icon	Action
Location	Click down-arrow and select location where test was ordered. **NOTE:** Only orders not yet placed on a requisition for the selected location display. The default is the user default location.
Patient	• To view orders for all patients, accept the *<All Patients>* default. • To search for a patient, click ... to display the search dialog. • To view all orders, click **All**.
Caregiver	Accept the default, *<All Caregivers>*, ***or*** click the down-arrow to select the caregiver who orders the test(s). **NOTE:** Only orders not yet placed on requisitions display.
Dates	Click ... to search and select a date range that includes the orders to process. • **Current range**: select date range to view orders. • **Specific dates**: enter the dates (MM/DD/YYYY) format or select dates from the calendar.

Creating requisitions

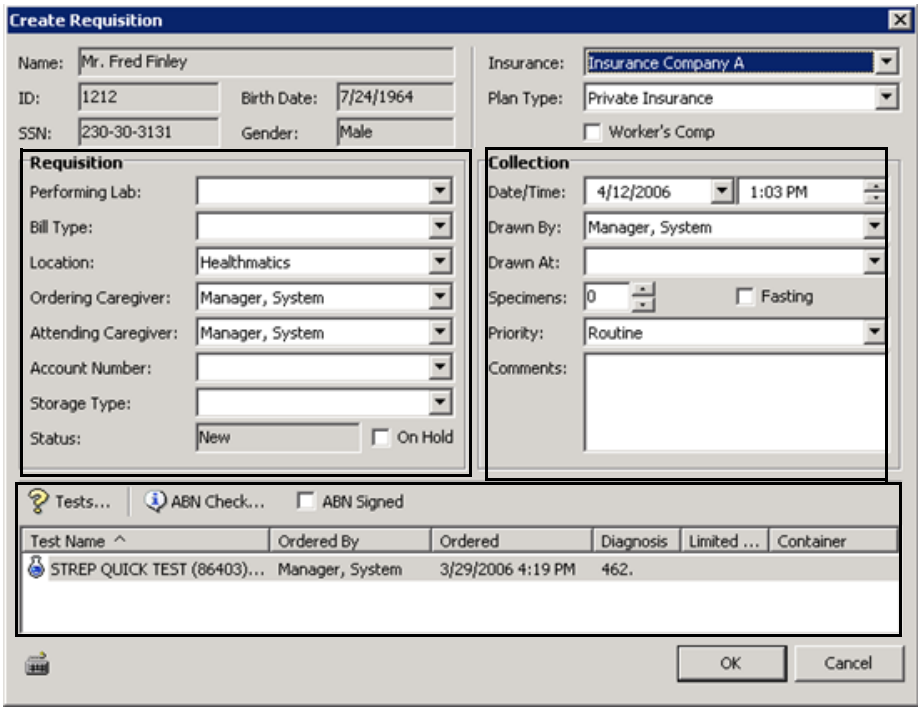
Use requisitions to send lab orders from HealthMatics EMR to external laboratories for processing. Requisitions can contain one or many lab orders, depending on laboratory preference.

Create a requisition for all orders within an encounter on the A/P screen, or on the Requisitions screen in Lab Order Entry or create a requisition for just one lab test. If an individual test is selected, only that test appears on the requisition for the Lab Order Entry screen.

To create requisitions

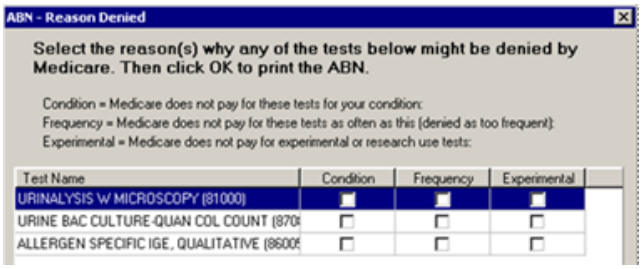
1. Access Lab Order Entry (see Accessing lab order entry on page 214.

2. Click **Order**.
3. Select an encounter or an order, then double-click it or click (Create Requisition).



Field	Action
Insurance	Click the *Insurance* down-arrow to select the appropriate insurance company.
Plan type	Click the Plan Type down-arrow to select the patient insurance type (*Medicare, Medicaid, Private Insurance, HMO/Managed Care, BCBS, Other, Self-Pay, Workers' Comp*). • Some laboratories require plan type information to process requisitions for orders. Refer to the ***Clinical Customization*** manual for information on *Ins Plan Type Required* checkbox. • The Worker's Comp checkbox automatically selects if *Worker's Comp* is the Plan Type or if the correct information is provided over the interface from your Practice Management System.
Requisition	
Performing lab	Select the laboratory to receive the requisition.
Bill type	Informs laboratory who should be billed for the lab work. • **Client** - Laboratory bills client (EMR site) who ordered the lab work based on the *Account Number* specified on the requisition. • **Patient** - Laboratory bills patient directly. • **Third party** - Laboratory bills the patient insurance company. An insurance company is required if you select this option.

Field	Action
Location	Value defaults to location where order is placed. Location information prints on requisition.
Ordering caregiver	Value defaults to caregiver who ordered test in A/P. Select the caregiver who ordered the test (result notifications return to that caregiver).
Attending caregiver	Value defaults to caregiver who ordered test in A/P. Select the attending caregiver.
Account Number	Defaults to the performing lab account number. Select the performing lab ID number.
Storage type	Select a storage type (*Ambient, Refrig, Frozen,* and so forth). All tests on the requisition must have the same storage type. When *Storage Type* is required, a message displays if one is not selected.
Status	Displays the requisition status, for example, *New* when the requisition is created.
On Hold Checkbox	Click to indicate the requisition is not complete and should not be sent across the interface.
Collection	
Date/Time	• **Date** - Click drop-down arrow to display calendar to select collection date if other than today. • **Time** - Enter the time or click the scroll arrows to select collection time.
Drawn By	Select caregiver who collected specimen.
Drawn At	Select location where specimen collected.
Specimen	Use scroll arrows to indicate number of specimens collected.
Fasting	Click **Fasting** checkbox if patient fasted prior to collection.
Priority	Select appropriate priority (defaults to *Routine*).
Comments	Add any additional specimen collection comments if desired.

Field	Action
Tests	Click to select tests to include on the requisition. **NOTE:** Tests checked depend on selection from previous screen. If an encounter was selected, all tests are checked. However, if a single test was selected, only that test is checked on the requisition by default. • To include a test (or exclude it) check or uncheck the box. • To include all tests on the requisition, click **Check All**. Click **OK** to exit
ABN Check	Click for ABN reason Medicare may not cover the service.  **NOTE:** Each Medicare patient must sign an Advance Beneficiary Notice (ABN) form for laboratory tests Medicare does not cover. The ABN includes the reason Medicare may not cover the laboratory test. On the ABN, patients indicate they will pay for the test themselves or choose not to have the test performed. • **Condition** - Medicare does not pay for the test for the specified medical condition. • **Frequency** - Medicare does not pay due to the time interval since the last test. • **Experimental** - Medicare does not pay due to the experimental/research nature of the test.
ABN Signed Checkbox	Click to select box indicating patient signed an ABN for the test(s) ordered.

4. Click **OK** to create the requisition.

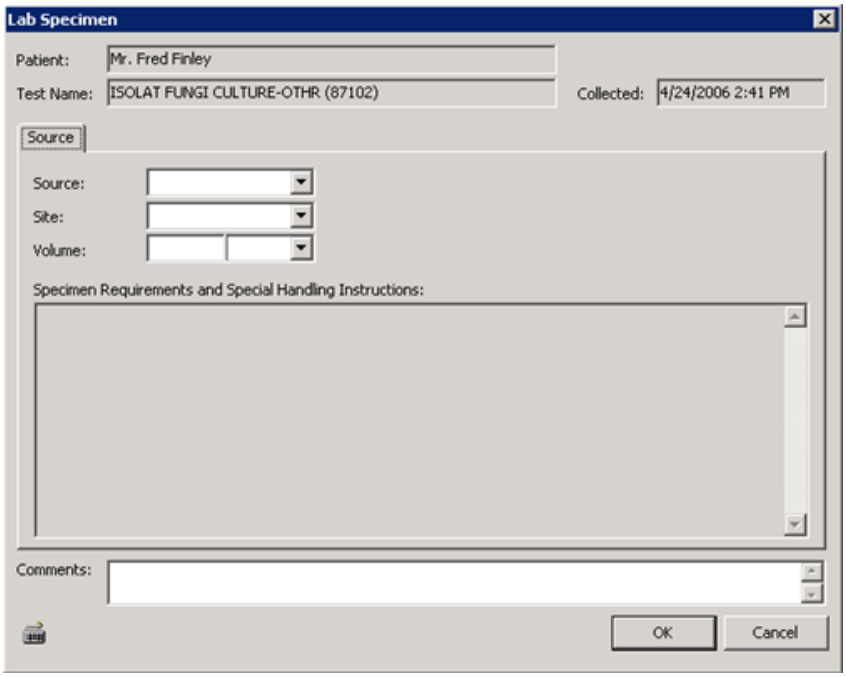
To enter specimen collection information

When creating or editing a requisition if specimen collection prompts were designated for any of the tests included (Source, Gyn Cytology, AFP, or Blood Lead tests), the appropriate Lab Specimen dialog box automatically displays. See Lab Order Entry in HealthMatics EMR ***Clinical Customization*** manual for detailed information.

Four example Lab Specimen screens follow below.

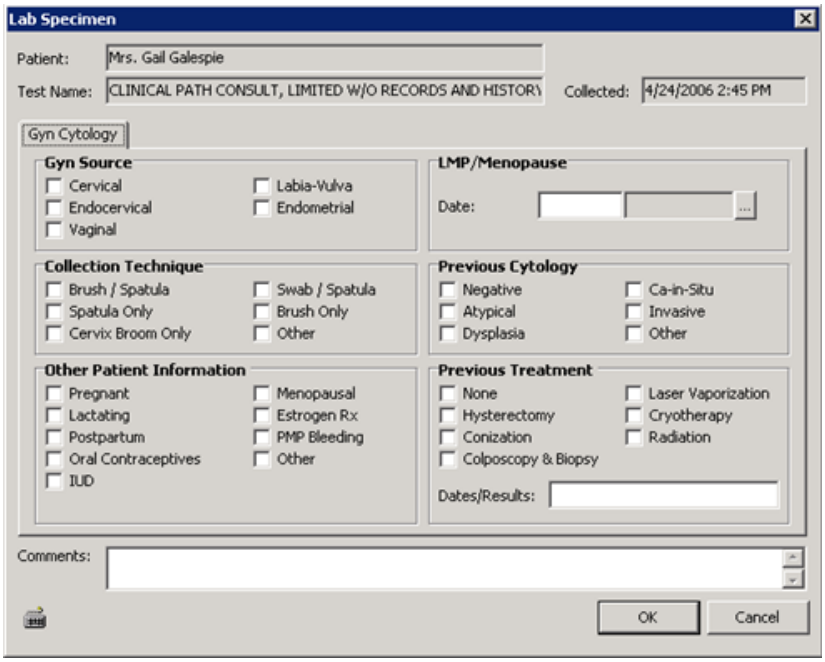
NOTE: The specimen collection screens display only if an external code with the appropriate Lab Specimen Collection Prompt was designated for one or more lab tests on the requisition.

Specimen Collection Prompt – Source screen



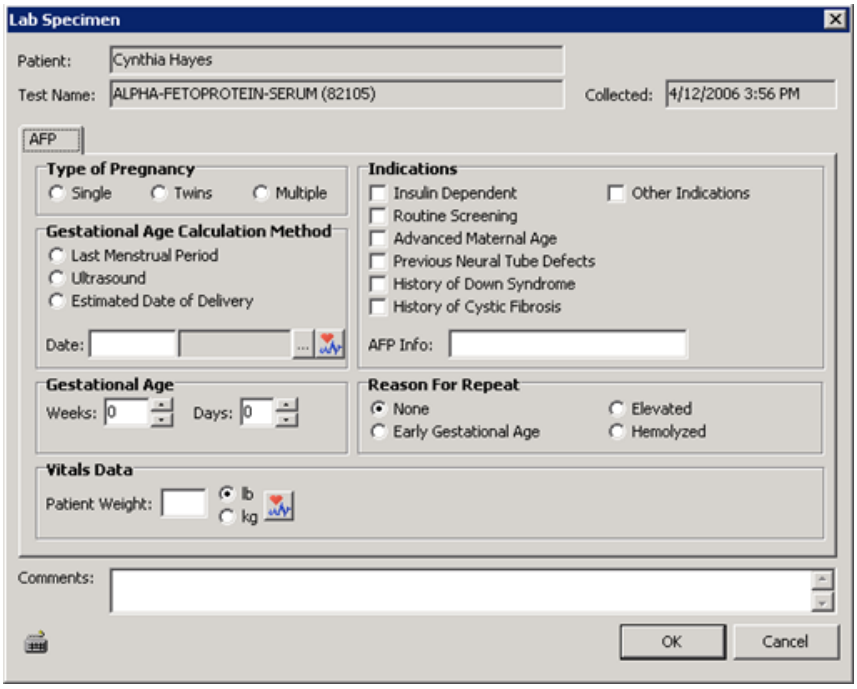
1. At *Source, Site*, and *Volume* (for the specimen), enter appropriate information.
2. At *Specimen Requirements and Special Handling Instructions* view any information given.
3. At *Comments*, enter any required information.
4. Click **OK**.

Specimen Collection Prompt – GYN Cytology screen



1. Click to select check-boxes as appropriate.
2. **(Required)** At *LMP* (last menstrual period)/*Menopause* enter a date. Use the Search … button if desired.
3. At *Previous Treatment* and *Dates/Results*, enter information as needed.
4. At *Previous Cytology,* check boxes as needed.
5. At *Comments*, enter comments as needed.
6. Click **OK**.

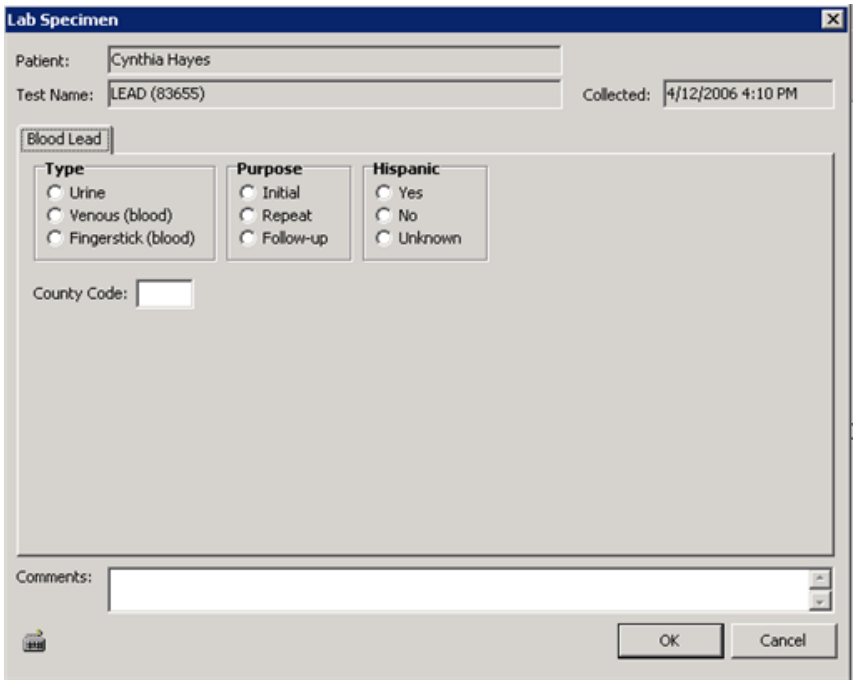
Specimen Collection Prompt – AFP screen



1. At *Type of Pregnancy,* click appropriate type.
2. At *Gestational Age Calculation Method*, do the following:
   - Click to indicate the gestational age calculation method.
   - At *Date*, enter the date that corresponds to the option selected (*Last Menstrual Period, Ultrasound,* or *Estimated Date of Delivery*) ***or*** click ... to search icon ***or*** click to default LMP from vitals.
3. At *Gestational Age*, use spin-arrows to enter gestational age in weeks and days.
4. At *Indications*, click checkboxes as needed and enter *AFP information* as needed.

   NOTE: A maximum of 20 characters can be entered.
5. At *Reason for Repeat*, click to indicate the reason for repeating the test, if necessary.
6. **(Required)** At *Vitals Data*, enter patient current weight in the field, click either *lb* or *kg* ***or*** click to default weight from vitals.
7. At *Comments*, enter a comment if needed.
8. Click **OK**.

Specimen Collection Prompt – Blood Lead



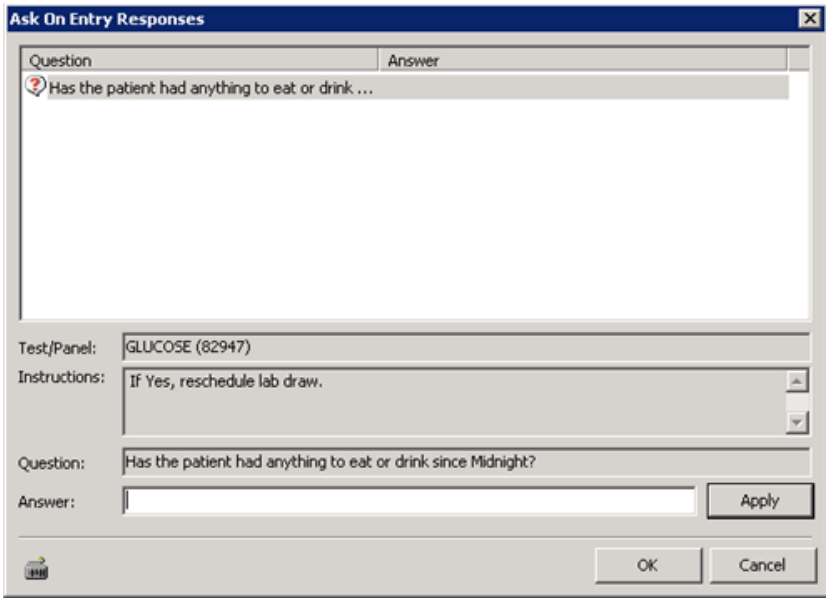
1. In *Type* and *Purpose*, click radio buttons to select type and purpose of the test.
2. In *Hispanic*, indicate whether the patient is Hispanic (to meet LabCorp specifications).
3. In *County Code*, enter the code for the county in which the specimen was collected (must be 2 to 5 characters).
4. In *Comments*, enter comments as needed.
5. Click **OK**.

Answering ask on entry (AOE) questions for orders

1. Access Lab Order Entry (see Accessing lab order entry on page 214).
2. Click **Order**.
3. Select an encounter or an order that has AOE questions mapped to it, then double-click it.
4. Click **OK** to display Create Requisition.
5. Complete any additional information needed, then click **OK**.

   NOTE: If a lab source was defined, the Lab Source dialog displays. Click **OK**.

6. If AOE questions were defined for the selected test/panel, the Ask On Entry Responses dialog appears.



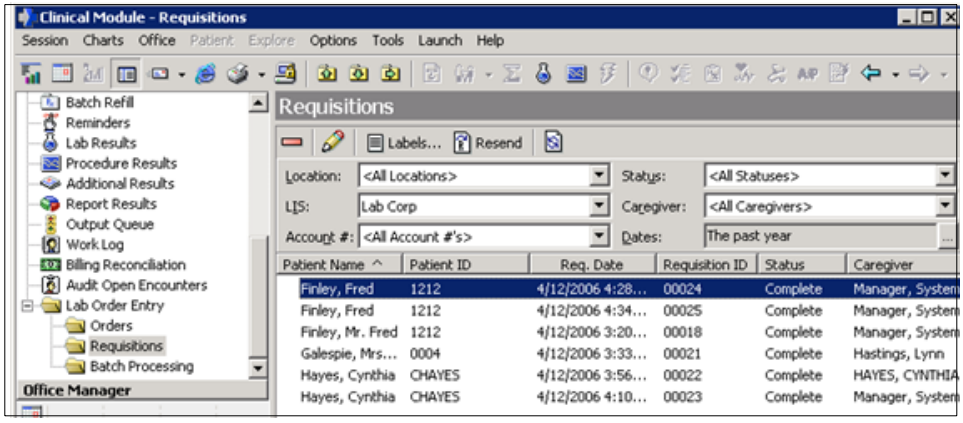
7. At *Answer*, type the answer to the question, then click **Apply** for the answer to display in the *Answer* column in the top pane.

8. Click **OK**.

Viewing/editing ask on entry questions on requisitions

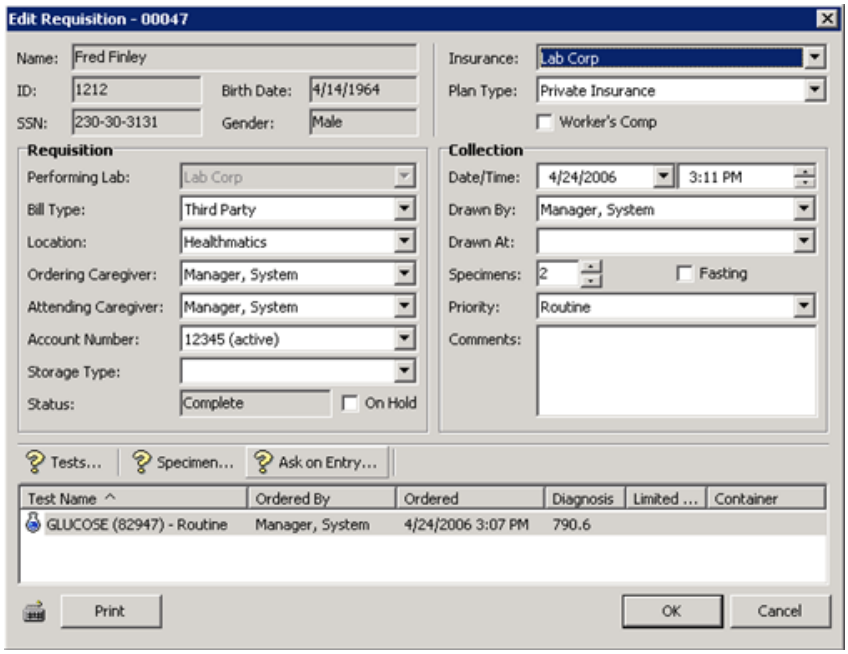
After orders are placed for labs that include Ask on Entry (AOE) questions, and the requisition created, you can view the AOE questions on the requisition.

1. From the HealthMatics EMR Menu bar, click **Office > Requisitions *or*** from the left pane, click **Requisitions**

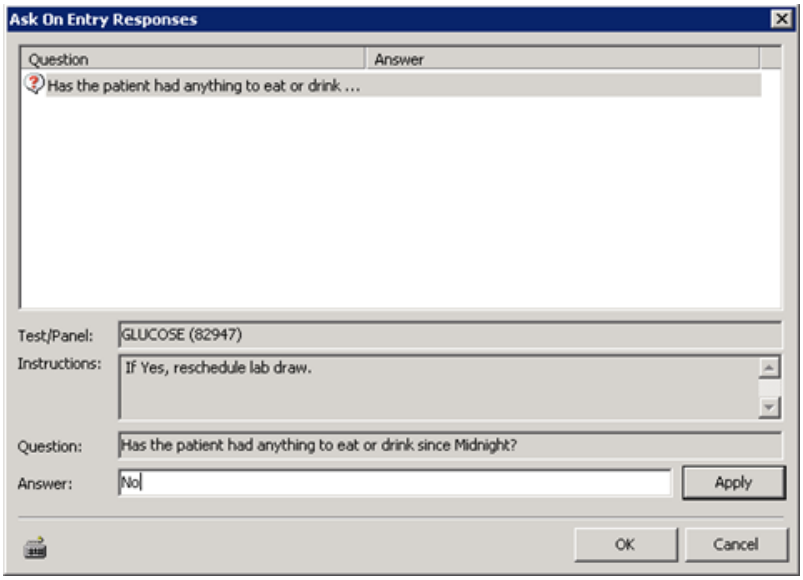

Clinical Module - Requisitions
Session Charts Office Patient Explore Options Tools Launch Help
Batch Refill
Reminders
Lab Results
Procedure Results
Additional Results
Report Results
Output Queue
Work Log
Billing Reconciliation
Audit Open Encounters
Lab Order Entry
Orders
Requisitions
Batch Processing
Office Manager
Requisitions
Labels... Resend
Location: <All Locations>
Status: <All Statuses>
LIS: Lab Corp
Caregiver: <All Caregivers>
Account #: <All Account #'s>
Dates: The past year
Patient Name | Patient ID | Req. Date | Requisition ID | Status | Caregiver
Finley, Fred 1212 4/12/2006 4:28... 00024 Complete Manager, System
Finley, Fred 1212 4/12/2006 4:34... 00025 Complete Manager, System
Finley, Mr. Fred 1212 4/12/2006 3:20... 00018 Complete Manager, System
Galespie, Mrs... 0004 4/12/2006 3:33... 00021 Complete Hastings, Lynn
Hayes, Cynthia CHAYES 4/12/2006 3:56... 00022 Complete HAYES, CYNTHIA
Hayes, Cynthia CHAYES 4/12/2006 4:10... 00023 Complete Manager, System

Secondary Toolbar	
	Delete a requisition - when you delete a requisition the ordered labs are placed back on the Orders page.
	Edit a requisition
	Labels - print labels dialog
	Resend requisitions across the Interface
	Refresh screen

2. Select the patient requisition that includes an AOE question, then double-click ***or*** click (Edit).



3. Select the test (if more than one test is listed) and click Ask on Entry to display the AOE questions and answers in Lab *Ask On Entry*.



NOTE: If the requisition does not include an AOE question, when the **Ask on Entry** button is selected a warning note displays that the requisition does not include an AOE question.

4. Do **one** of the following:

   - **IF** you are viewing the requisition, view the AOE answers and click **OK** to exit.
   - **IF** you want to edit the test, change the *Answer* as needed and click **OK** and **OK** again to exit Edit Requisition.

IMPORTANT!

Requisitions may not be edited if:

- An order(s) on the requisition has results entered.
- The requisition is turned over to the interface with a status of *Ready to Send, Wait for Resend,* or a status of *Sent OK*.
- When a requisition with Ask on Entry questions prints, the questions and answers provided print on the requisition.

Deleting requisitions

1. Access Requisitions.
   (See Viewing/editing ask on entry questions on requisitions on page 224.)
2. Select the Requisition to delete, then click .
3. Click **Yes** to confirm deletion.

IMPORTANT!

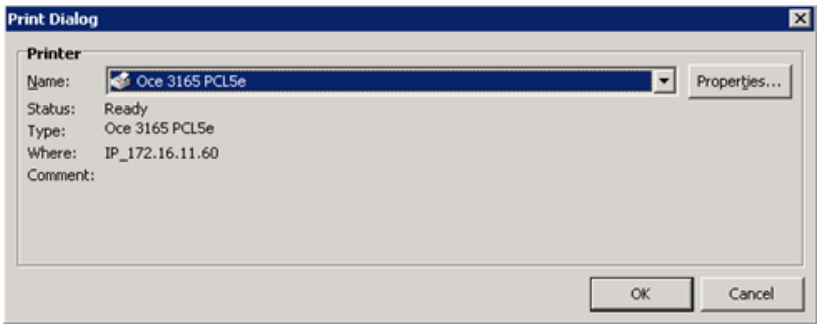
Requisitions may not be deleted if:

- An order(s) on the requisition has results entered.
- The requisition is turned over to the interface with a status of *Ready to Send, Wait for Resend,* or a status of *Sent OK*.

The ordered test on the requisition moves to the Orders page. The test is not deleted.

Printing requisitions

1. Access Requisitions (see Viewing/editing ask on entry questions on requisitions on page 224).
2. Select the Requisition, then double-click, or click to view the item to print.
3. Click **Print**.

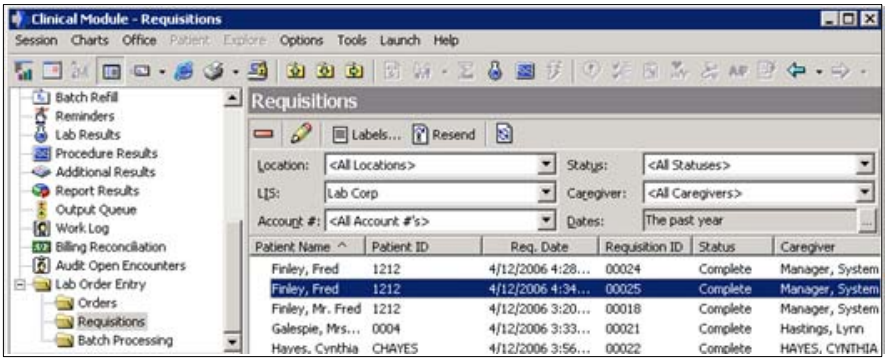


4. Click the *Name* down-arrow to select a printer if desired, or click **Properties** to adjust printer properties.
5. Click **OK**.

Processing requisitions

To access requisitions

1. From the HealthMatics EMR Menu bar, click **Office > Requisitions** or from the left navigation pane, click **Requisitions**.



Fields	Action
Location	*<All Locations>* is the default. Click down-arrow to select a location for which the user has access.
Status	*<All Statuses>* is the default. Click down-arrow to select a status. • **On hold** - Requisitions incomplete and not ready to be sent across the Interface. • **Complete** - Completed Requisitions only. • **Ready to send** - Requisitions ready to send across the interface. • **Wait for resend** - Requisitions waiting to be resent across Interface. • **Sent OK** - Requisitions sent across Interface. • **Error** - Requisitions received errors when sent across the Interface.
LIS	Click down-arrow to select Laboratory.
Caregiver	*<All Caregivers>* is the default. Click down-arrow to select a specific caregiver.
Account #'s	*<All Account #'s>* is the default. Click down-arrow to select
Dates	Default is *The past year*. Click ... (search button) to select a set date range.

2. Double-click a requisition to print (see Printing requisitions on page 226).

To resend requisitions

You can resend requisitions that had errors as well as those previously transmitted successfully.

1. Access Requisitions (see To access requisitions on page 227).
2. Select the requisition to resend, then from the secondary toolbar, click .

   NOTE: A warning message displays if the Interface is not enabled.

To print labels

1. Access Requisitions (see To access requisitions on page 227).
2. From the secondary toolbar, click .

3. At *Printer*, select a printer you use for labels.
4. At *Labels*, use the spin buttons to indicate how many labels you need.
5. Click **OK** (or **Cancel** to leave the box without printing labels).

   NOTES
   * Once you select a printer and click **OK**, the printer defaults on subsequent returns to this screen. If you change workstations, the system maintains the same default printer. Consequently, if the printer is not valid for your new workstation, you must pick a different printer.

   * The number of labels always defaults to 2.

   * *Priority* and *Ordered By* fields print on barcode labels.

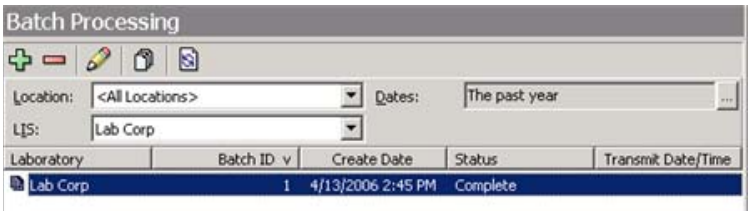
Processing requisition batches

Use *Batch Processing* to send electronic requisitions in batches and to print batch manifests (packing lists).

NOTE: In order to use batch processing with a bi-directional interface, the *Batch Processing* box on the Add Laboratory or Edit Lab screen must be checked (See HealthMatics EMR ***Clinical Customization*** manual for laboratory set up information.)

To access batch processing

1. From the HealthMatics EMR Menu bar, click **Office > Batch Processing** or from the left navigation pane, click **Lab Order Processing > Batch Processing**.



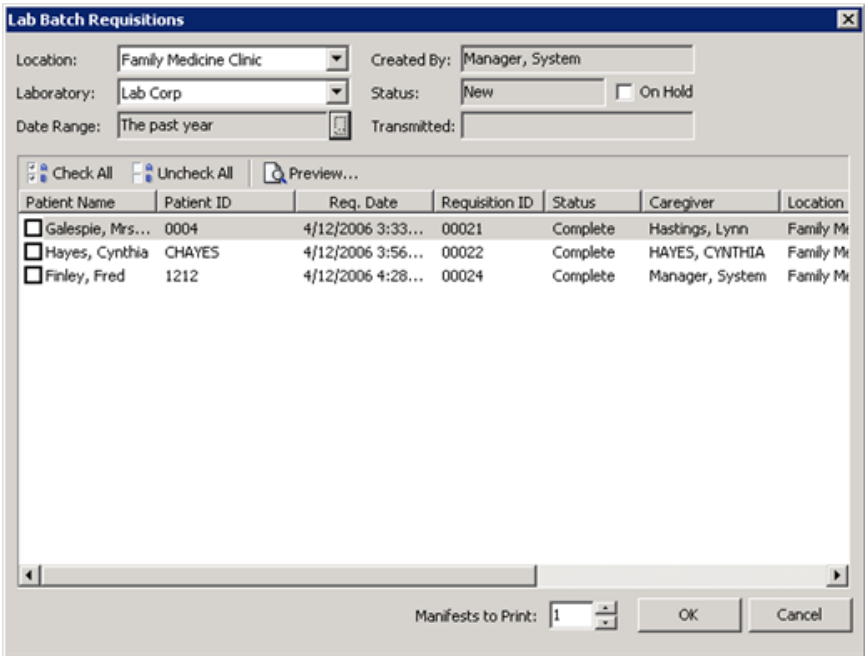
Field	Action
Location	<*All Locations*> is the default. Click down-arrow to select a location for which the user has access.
LIS	Click down-arrow to select Laboratory.

2. Select a batch to process.

To create lab order batches

NOTE: You must have requisitions created before you can process them in a batch.

1. Access Batch Processing (see To access batch processing on page 229).
2. Click ✚ to display Lab Batch Requisitions showing a list of requisitions with a *Completed* status not yet included in a batch.

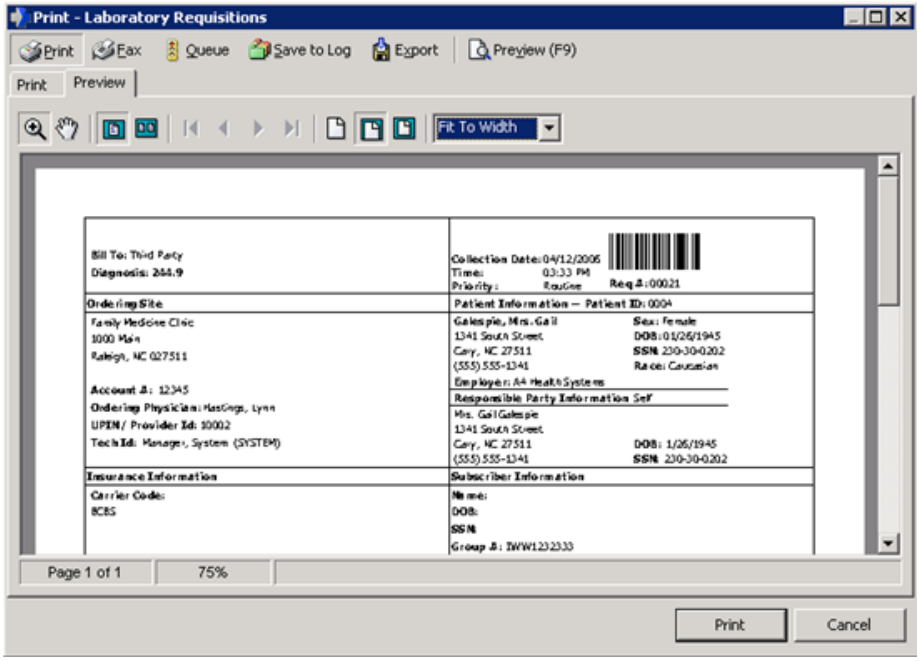


At *Location* and *Laboratory* Batch Processing selected items display, but can be changed from the drop-down list boxes.

3. At *Date Range*, click the ... (search button) to set the date range for requisitions.

   NOTES
   * Information displayed includes patient names and IDs, requisition dates and IDs, statuses, caregivers and location.

   * To view a requisition before including it in the batch, select it, then click **Preview**.



4. Check the box for those patient requisitions you want to include in the batch ***or*** click **Check All** to select all requisitions in the batch ***or*** click **Uncheck All** to remove all requisitions from the batch.

5. At *Manifests to Print*, indicate the number of packing lists to print.

6. Click *On Hold* **IF** the batch is not complete and should not be sent across the interface.

7. Click **OK**.
   The newly created batch displays in Batch Processing.
   Print box displays for you to select a printer to send the packing list.

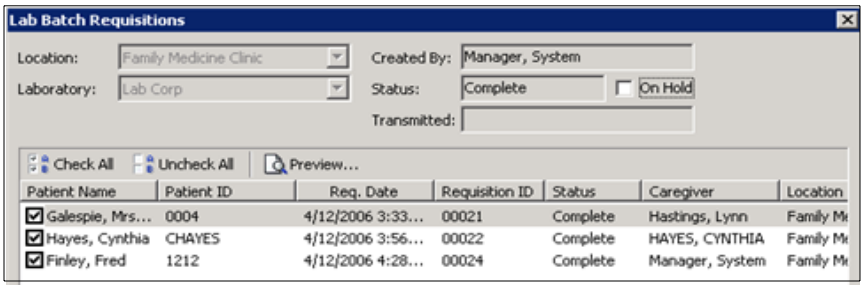
   NOTE: If the batch is not on hold and an interface is enabled for the selected laboratory, the *Status* for the batch and all requisitions in it will be set to *Ready to Send*. This tells the interface it is ready to be sent to the laboratory for processing and no longer editable.

To edit lab order batches

If the batch does not have a *Status* of *Ready to Send*, you can edit a batch to remove lab test requisitions before transmitting the batch.

NOTE: You cannot add a test to an already created batch. The batch would have to be deleted and a new batch started.

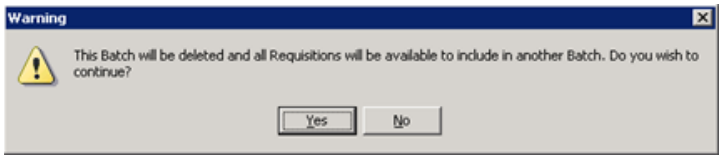
1. Access Batch Processing.
   (See To access batch processing on page 229.)
2. In Batch Processing, select a batch and click .



3. Click to deselect the *Patient Name* box to the left of any requisition(s) you do not want to include in the batch.
4. Click **OK**.
   The Print dialog displays to print the Manifest.

To delete lab order batches

1. Access Batch Processing (see To access batch processing on page 229).
2. Select a batch and click to display the following message.


Warning
This Batch will be deleted and all Requisitions will be available to include in another Batch. Do you wish to continue?
Yes
No

3. Click **Yes** to delete the batch and to make all requisitions in the batch available for other batches; otherwise, click **No**.

To preview and print batch manifests (packing lists)

There are two ways to print the Manifest/Packing List for a batch from the Batch Processing screen.

- Select the batch and click **> Lab Batch (Preview)** to print the Manifest/Packing List for the batch.
- Select the batch, double-click or click **Edit**, then **OK**.
- Complete printing options, then click **OK**.

Patient Merge

The *Patient Merge* function in HealthMatics EMR makes it quick and easy for a caregiver or system administrator to merge two or more charts into one. In addition, you can review the merge history and reverse a merge if it was performed in error.

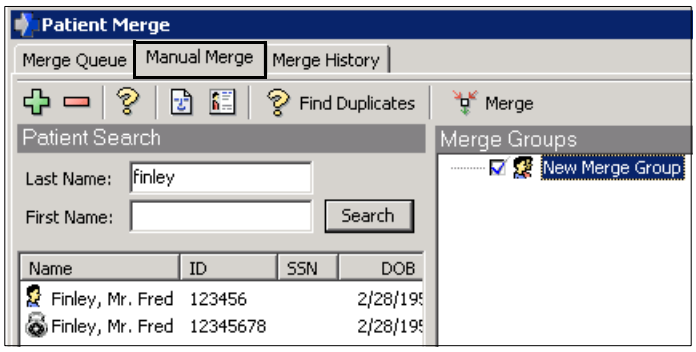
In *Patient Merge*, you can do all of the following:

- **Manual merge** - If your practice does not have a PMS, you can merge charts directly in the HealthMatics EMR application (Manual Merge).
- **Merge queue** - If your practice uses the HealthMatics Ntierprise Practice Management System (PMS), when a patient chart is inactivated in the PMS, Ntierprise sends a message to the HealthMatics EMR *Merge Queue*. From there, you can review the face sheets and demographics of the duplicate charts before approving or rejecting the merge.
- **Merge history** - Review the merge history of any charts that have been merged or have had merges reversed (History).

Manually merging patient charts

IF you do not have a Practice Management System (PMS), you can merge patient charts directly in HealthMatics EMR.

1. From the menu bar, select **Tools > Patient Merge** to search for patients to merge on the **Manual Merge** tab.

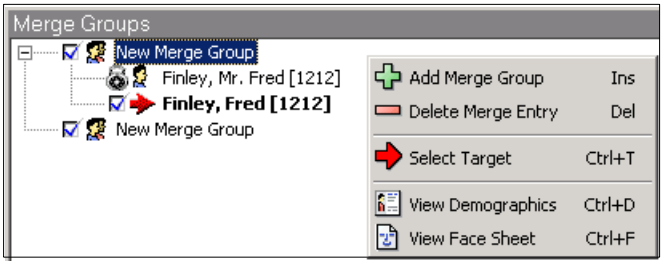


2. Find duplicates by doing **one** of the following:
   - **To search by patient**, in the *Patient Search* box enter the last (and possibly first) name of the patient and click **Search**. All patients with that name display in the box below.

     NOTE: Scroll to the right to view date of birth (*DOB*) and *Sex*.

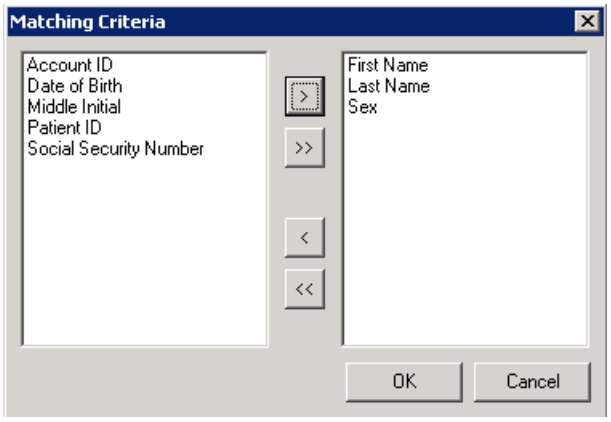
     > Press **Insert** on your keyboard ***or*** click (Add Merge Group) to create a *New Merge Group* for each set of charts that you want to merge.

> Select a *New Merge Group* on the right, and then double-click each duplicated patient on the left to add them to the merge group.



Right-click to display menu

- **To search for ALL duplicates**, on the toolbar click (Find Duplicates) to display Matching Criteria.



> Double-click a search criterion in the left pane ***or*** select it and click .

NOTES

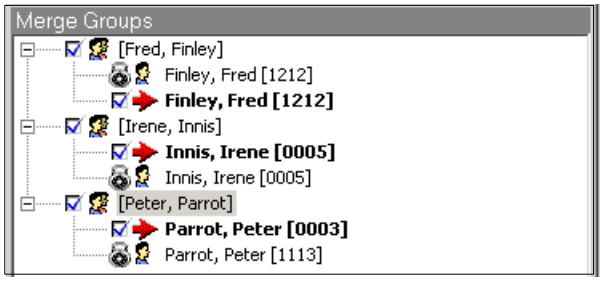
***** To deselect a criterion, double-click it in the right pane ***or*** select it and click .

* To select or deselect all criteria, click ***or*** , respectively.

WARNING!

Finding all duplicates using matching criteria may be time-consuming if your database is large and you have much duplication. During the time that the system is searching for duplicates, you will not be able to access HealthMatics EMR for other work. A progress bar for the search displays in the lower right corner of the *Manual Merge* tab.

> After selecting criteria, click **OK**.



If needed, in the *Merge Groups* pane on the right, click (**+**) to display all duplicate patients.

Groups of charts that fit the selected criteria display in the *Merge Groups* pane. Search criteria (and order) selected are represented by the data in [brackets].

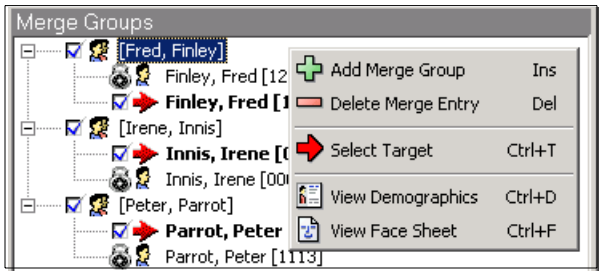
NOTES
***** Patient names preceded by lock icons ( ) have charts pulled on a caregiver's desktop. To proceed with the merge, determine who has the chart pulled and have the caregiver file it. Then proceed with the merge.

* Alternately, you can deselect the box in front of the *Merge Group* that includes the locked chart or patient, and continue the merge process for other merge groups.

3. **Review patient charts** - To review the charts before deciding whether to merge them, and to determine which one to make the target (usually the one with the most data in it), select a chart in a merge group and do the following:

   - **Face shee**t - Press **Ctrl+F** on your keyboard ***or***, on the toolbar or right-click menu, click (Face Sheet).
   - **Demographics** - Press **Ctrl+D** on your keyboard ***or*** on the toolbar or right-click menu, click (Demographics).

4. **Select target charts** - Select a target for the group by highlighting the appropriate chart in the *Merge Group* and pressing **Ctrl+T** on your keyboard ***or*** by clicking (Select Target) on the pop-up menu or toolbar.



NOTE: Right-click for the pop-up menu.

5. **Remove patients or groups** - To remove a patient from a merge group or a complete merge group, select the patient or the group (respectively) and press **Delete** on your keyboard ***or*** click (Delete Merge Entry). The removed patient or group of patients return to the *Patient Search* box on the left.

6. **Merge** - To merge the charts in each *Merge Group*, do the following:

   - Verify that all boxes to the left of each patient and group that you wish to merge are checked.

- Press **Ctrl+M** on your keyboard or click **Merge** on the toolbar.

  > A message displays the progress of the merge and then closes.

  > Green checks display in front of the charts that have been merged into the target charts in each group.

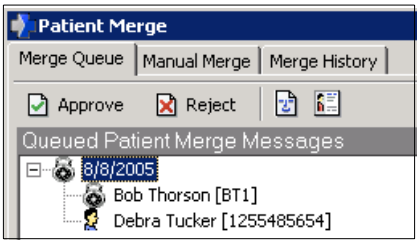
7. To close Patient Merge, click the **X** in the upper right corner.

Using the merge queue

IF you have the HealthMatics Ntierprise Practice Management System, when you inactivate a duplicate patient chart in Ntierprise, the system sends a message to the *Merge Queue* in HealthMatics EMR.

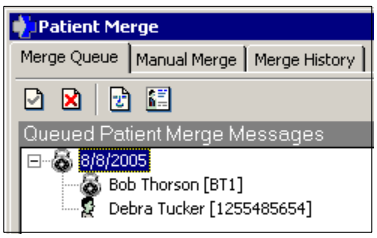
Messages in this queue list the date and time the chart was inactivated in Ntierprise. A caregiver or system administrator with the appropriate security can then review the face sheets and demographics of the duplicate patient charts that are queued for possible merging, and either approve or reject the merge.

1. From the HealthMatics EMR menu bar, select **Tools > Patient Merge** to display queued messages from your PMS (if any).



2. **To review queued merges:**

   - Click (**+**) in front of a merge message to list the patients that were merged.



   - With a chart selected, press **Ctrl+F** on your keyboard ***or*** on the toolbar click (Face Sheet) and press **Ctrl+D** on your keyboard ***or*** on the toolbar click (Demographics) to review the two patient charts before deciding whether to approve or deny the merge in HealthMatics EMR.

3. **To approve the merge in the EMR:**

   - Highlight the *Queued Patient Merge Message* that you wish to approve.

- Press **Ctrl+A** on your keyboard ***or*** click (Approve Merge).
  The merge message is removed from the queue and all the checked merges are processed in HealthMatics EMR.

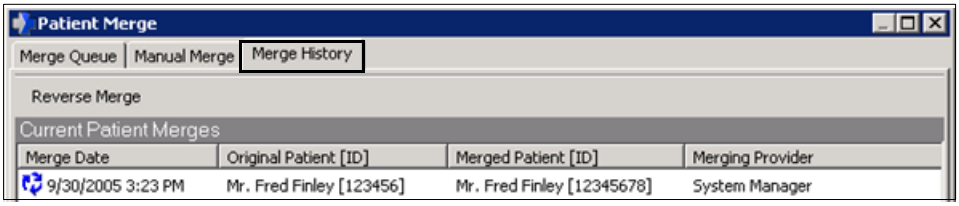
4. **To reject a merge in the EMR:**
   - Highlight the *Queued Patient Merge Message* that you wish to reject.
   - Press **Ctrl+R** on your keyboard ***or*** click (Reject Merge).
     The highlighted merge is rejected and the message is removed from the queue.

     IMPORTANT! Rejecting a merge in the EMR does **not** reverse it in the Practice Management System. To do that, you must go through your PMS.
5. To close Patient Merge, click the **X** in the upper right corner.

Reviewing merge history

HealthMatics EMR keeps a record of all patient merges.

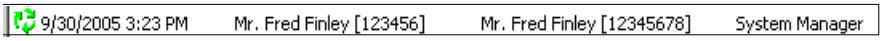
1. From the menu bar, select **Tools > Patient Merge**.
2. Click the **Merge History** tab.



A separate line item displays for **each** chart that has been merged into a group. Information saved includes the following.

- **Merge date** - Date the merge was made.
- **Original patient (ID)** - The original name and ID number of the patient that was merged into another.
- **Merged patient (ID)** - The target chart name and ID into which the patient was merged.
- **Merging provider** - The user who performed/approved the merge.

3. To reverse a merge, select it and click **Reverse Merge**.
   - To see the reversal, select the Show all merges check box in the bottom left corner of the screen.

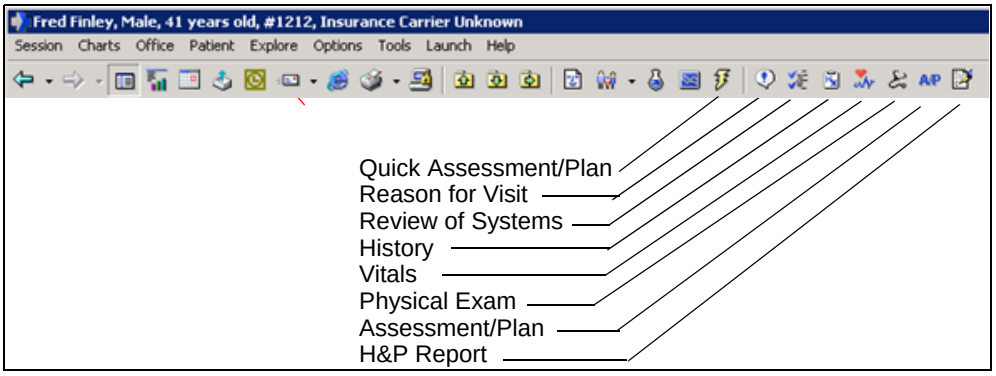
     The merge icon changes from blue to green for merges that have been reversed.
4. To close Patient Merge, click the **X** in the upper right corner.

3. Patient Contact Functions

HealthMatics EMR provides a point and click method of documenting patient visits and recording immediate, legible documentation, measurements and results in patient charts.

When you pull a patient chart, the toolbar icons for “contact screens” become enabled. These include: Quick Assessment/Plan, Reason for Visit, Review of Systems, History, Vitals, Physical Exam, Assessment/Plan, and History & Physical. All of these (and more) are used to document patient visits in the Electronic Medical Record.

NOTE: The arrangement of toolbar icons can be customized to suit caregiver preferences (see Editing options on page 108).



Data Libraries

While customizing your EMR (see the **Clinical Customization** manual) and when documenting patient encounters, you will use the following purchased databases.

- **ICD-9** - The International Classification of Diseases is a classification system for diagnoses published by the American Medical Association (AMA) used in billing statements and Medicare claims.
- **SNOMED** - The Systematized Nomenclature of Medicine is a classification system for human and veterinary medicine. The SNOMED database is broader than the ICD-9 database and other purchased databases. Caution: Please test billing accuracy when using a SNOMED code.
- **CPT** - The Current Procedural Terminology database is a classification system for medical procedures and treatments used for billing.
- **HCPCS** - The Health Care Financing Administration (HCFA) Common Procedure Coding Systems (HCPCS) Level II database is used to document supplies, medical equipment, injectables, and non-physician services. The system is used in patient billing, if used in conjunction with a PMSLink and a PMS.
- **Medi-Span** - The Medi-Span database contains currently available medications, along with codes for manufacturer, product, and packaging identification. This database is updated quarterly. It includes the following:
  - > Patient education including a medication's purpose, use, precautions, side effects and other useful information.
  - > Medication-allergy, medication-medication, and medication-drug/alcohol interaction information.
- **CRS** - The Clinical Reference System database contains printable patient health care advisory information. The database contains three modules:

  NOTE: Sports Medicine and Cardiology modules can replace one of the standard three by request.

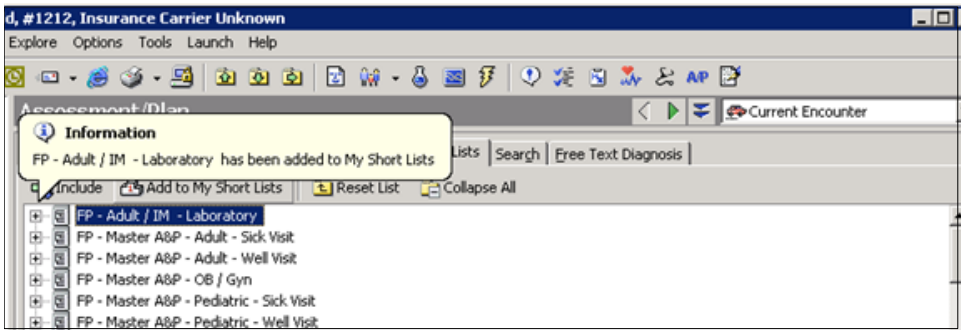
  - > Adult Health Advisor
  - > Pediatric Advisor
  - > Women's Health Advisor
- **LifeART** - Anatomical images are available in all contact screens. You can select an image from the Image tab after selecting **Notes**. You can then make notations on the image as part of your documentation. These images can also be included in exam templates during customization.

My Short Lists

Reason for Visit (CC/HPI), History (all eight areas), (Quick Assessment/Plan), and **A/P** (Assessment/Plan) all include a *My Short Lists* tab. The *My Short Lists* tab holds short lists an individual caregiver uses most often on those contact screens. In **Options > Edit Options > My Short Lists**, you can specify defaults and put these "favorites" in the order you prefer. (See Setting caregiver options for my short lists on page 240.)

Specifying my short lists for assessment/plan

1. Open a patient chart and, from the toolbar or left pane, click (Quick Assessment/Plan) or **A/P** (Assessment/Plan).

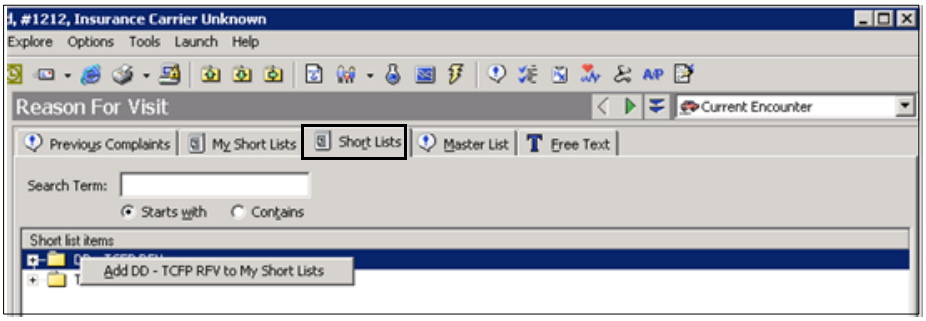

d, #1212, Insurance Carrier Unknown
Explore Options Tools Launch Help
Current Encounter
Information
FP - Adult / IM - Laboratory has been added to My Short Lists
Search
Free Text Diagnosis
Include
Add to My Short Lists
Reset List
Collapse All
FP - Adult / IM - Laboratory
FP - Master A&P - Adult - Sick Visit
FP - Master A&P - Adult - Well Visit
FP - Master A&P - OB / Gyn
FP - Master A&P - Pediatric - Sick Visit
FP - Master A&P - Pediatric - Well Visit

2. Click the **Short Lists** tab and **Collapse All**.
3. Right-click a short list you commonly use (or just select it) and click **Add to My Short Lists**).

NOTE: If the short list can be added, the bubble message shown above appears and the list is copied to the *My Short Lists* tab. If a selected item cannot be added (usually because you have selected a subfolder **under** the short list), a Warning message tells you to *"Please select a Short List."*

Specifying my short lists for reason for visit

1. Open a patient chart and, from the toolbar or left pane, click (Reason for Visit).

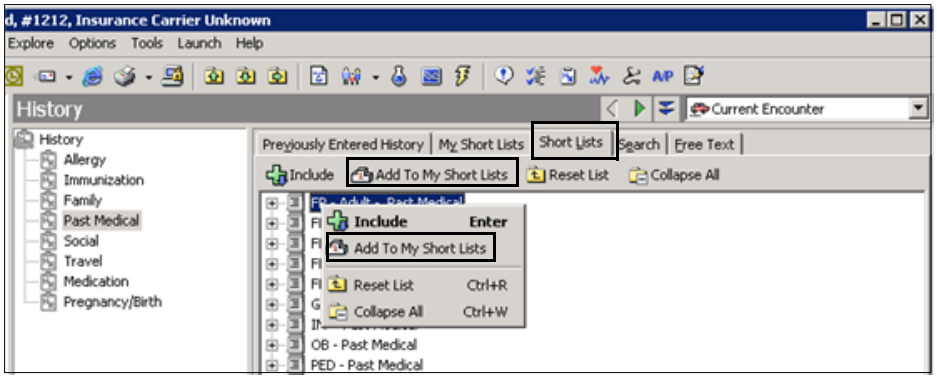


2. Click the **Short Lists** tab.
3. **Right-click** a short list and then click the popup message, **Add** (name of short list) **to My Short Lists**.

NOTE: If the short list can be added, a bubble message confirms, *(Name of short list) has been added to My Short Lists."* If the short list cannot be added (either because you have selected an item below the short list level or have already added the selected item to *My Short Lists*), a Warning appears.

Specifying my short lists in history

1. Open a patient chart and, from the toolbar or left pane, click (History).
2. In the left pane of the *History* view, select any category **except** *Immunization*.



3. Click the **Short Lists** tab.
4. **Right-click *or*** select a favorite short list and click **Add to My Short Lists**.

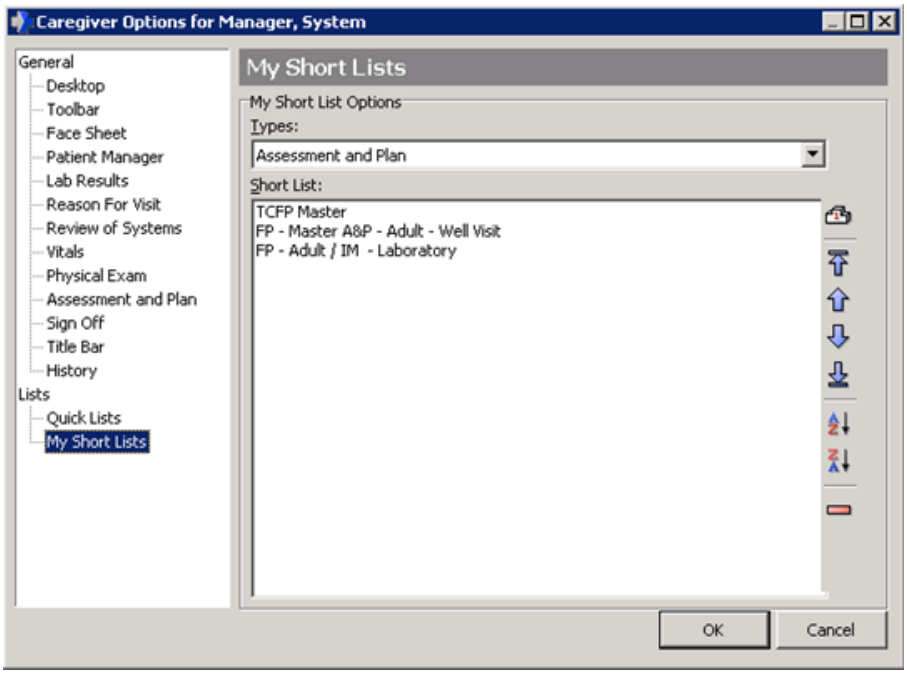
NOTE: If the short list can be added, a bubble message confirms, *(Name of the short list) has been added to My Short Lists.* The list is copied to the *My Short Lists* tab. If the short list cannot be added (either because you have selected an item below the short list level or have already added the selected item to *My Short Lists*), a Warning appears.

Setting caregiver options for my short lists

After specifying My Short Lists in Reason for Visit, History, and Assessment/Plan (see My Short Lists on page 239), you can set caregiver options for sorting the lists, setting default short lists, or deleting short lists from your specified favorites.

1. From the HealthMatics EMR menu bar, select **Options > Edit Options**.
2. In the left pane, click **My Short Lists**.

3. Click the **Types** down-arrow and select the type of list you want to sort. Short lists you specified for that type display in the pane below.



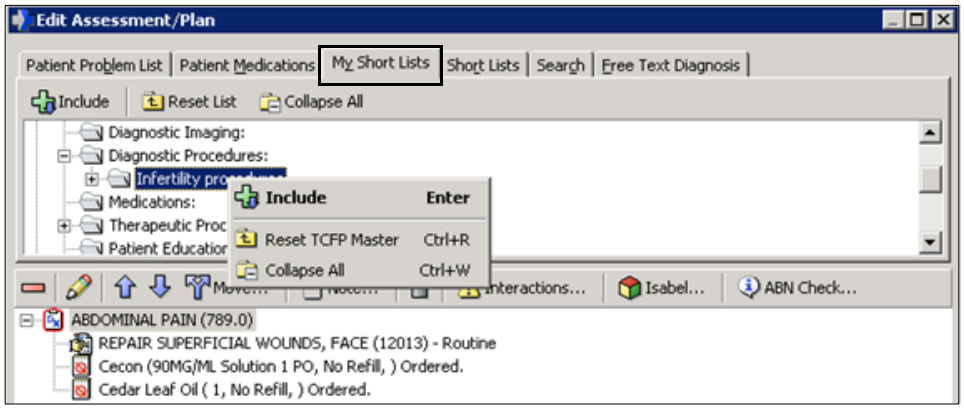
4. Select a list and click icons to do the following:

Icon	Name	Use
	Make Default	Make selected list the default for *My Short Lists* tab. This is a caregiver default.
	Move to Top	Move selected list to top.
	Move Up	Move selected list up one position.
	Move Down	Move selected list down one position.
	Move to Bottom	Move selected list to the bottom.
	Sort Ascending	Sort short lists in ascending order.
	Sort Descending	Sort short lists in descending order.
	Delete	Delete selected list from the *My Short Lists* tab. This does not delete the short list from the system, just the tab.

5. Click **OK** to save your changes and exit.

Adding my short list items to current encounters

1. Open a patient chart, and from the toolbar, click to display Assessment/Plan.
2. Click the **My Short Lists** tab.



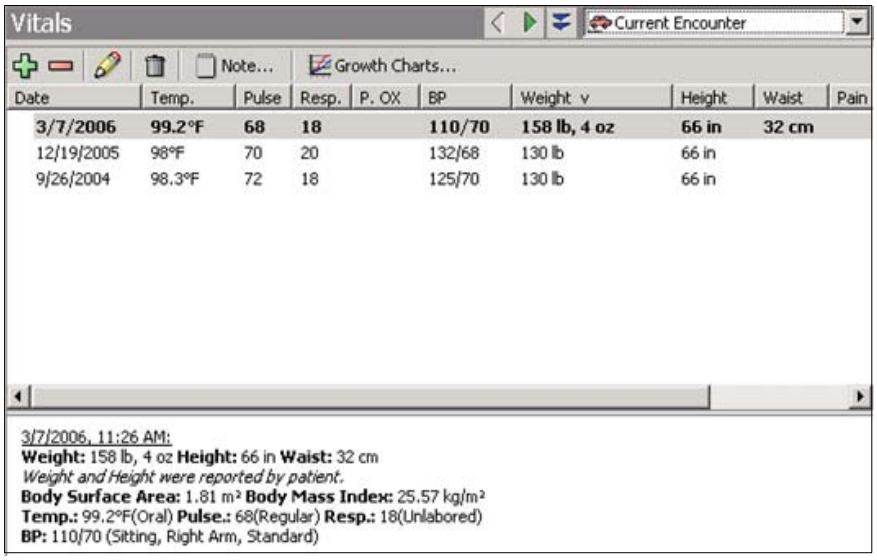
3. Select an item and do **one** of the following:
   - Click **Include** ***or***
   - Drag the item and drop it in the encounter pane below ***or***
   - Right-click and select **Include** ***or***
   - Double-click the item.

Vitals

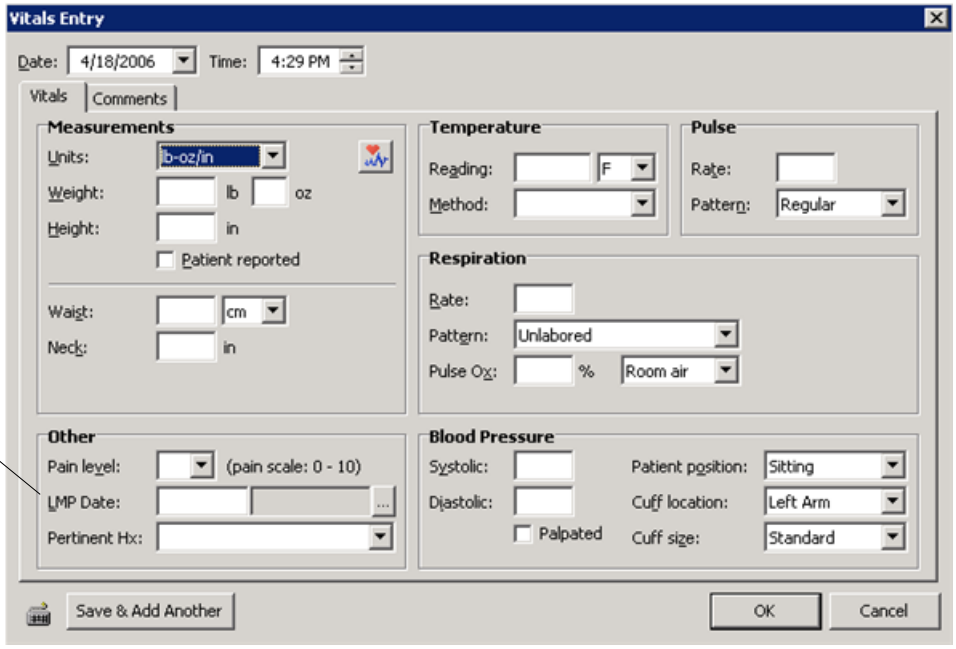
Use the Vitals view to document patient vital signs and growth chart data.

Documenting vitals

1. In HealthMatics EMR, pull a patient chart and, from the left pane or toolbar, click (Vitals).


Vitals
Current Encounter
Note...
Growth Charts...
Date
Temp.
Pulse
Resp.
P. OX
BP
Weight v
Height
Waist
Pain
3/7/2006 99.2°F 68 18 110/70 158 lb, 4 oz 66 in 32 cm
12/19/2005 98°F 70 20 132/68 130 lb 66 in
9/26/2004 98.3°F 72 18 125/70 130 lb 66 in
3/7/2006, 11:26 AM:
Weight: 158 lb, 4 oz Height: 66 in Waist: 32 cm
Weight and Height were reported by patient.
Body Surface Area: 1.81 m² Body Mass Index: 25.57 kg/m²
Temp.: 99.2°F(Oral) Pulse.: 68(Regular) Resp.: 18(Unlabored)
BP: 110/70 (Sitting, Right Arm, Standard)

2. From the Vitals secondary toolbar, click to display Vitals Entry.



In a child's chart, this will be Head Circumference

3. At *Date*, accept the default (current date) ***or*** click ... and select a different date.
4. At *Time*, accept the default (current time) ***or*** click the spin-arrows to set a different time ***or*** click to highlight and then type a different time.
5. At *Measurements*, select the appropriate unit measurement and do the following:
   - Enter the *Weight* and *Height*.

     NOTE: When *Weight* and *Height* have been filled in, *Body surface area* and *Body mass index* display.
   - If a patient is physically unable to use the scale, check *Patient reported,* if height/weight was not actually measured during the visit.
   - Click to copy the measurements from the previous visit into the fields. You can then compare the current weight and height to the previous weight and height, and enter the current weight and height instead, if desired.
6. At *Waist Circumference*, enter the numeric measurement. Use the down-arrow to choose units in either cm or in.
7. At *Pain Level*, click the down-arrow and select the level of pain on a 0-10 scale.
8. If the patient is a female, at *LMP Date*, enter the date of the Last Menstrual Period in mm/dd/yyyy format ***or*** click the ellipsis ... button to select the date.

   NOTE: The *Last Menstrual Period Date* field displays only if the patient is female and age 6 or older. If the patient is under 3 years of age, the *Head Circ.* (circumference) field displays instead.
9. Enter *Temperature, Pulse, Respiration,* and *Blood Pressure* data as desired.

   NOTE: The pulse oximeter reading is a measurement of the percentage of

hemoglobin (Hb) that is saturated with oxygen with each pulse beat. It is measured using a probe that is attached to the patient's finger or earlobe. An oximeter detects hypoxia before the patient becomes clinically cyanosed. Pulse Ox is always displayed on the H&P if data are provided. It has also been added in Results Summary.

10. To record additional vitals taken, such as bilateral or orthostatic blood pressures, click as many times as needed.

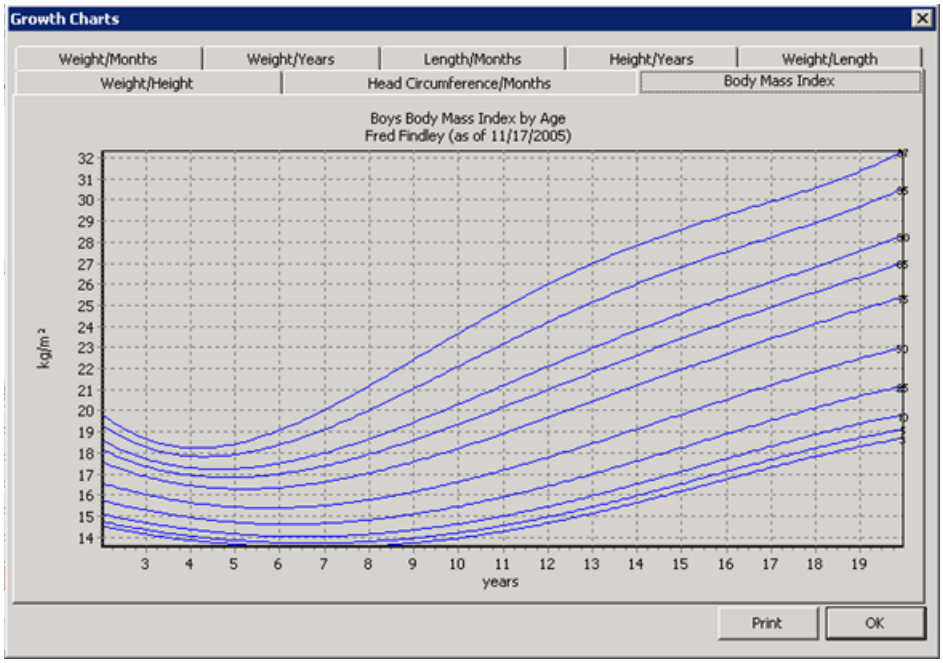
    NOTE: The time vitals were taken displays on the H&P.

11. Click the **Comments** tab to enter comments about the vitals if needed.
12. Click **OK** to accept the data entered.
13. Use the icons on the secondary toolbar to do any of the following tasks:

Icon	Name	Action
	Add Vitals	Click to add vitals data to the current encounter.
	Delete Vitals	Click to delete vitals for the current encounter or mark a selected entry erroneous.
	Edit Vitals	Click to edit vitals for the encounter or mark a selected entry erroneous.
	Clear	Click to delete all vitals data entered during the encounter.
	Note	Click to enter a vitals note for the current encounter.
	Growth Charts	Click to view or print growth charts.

Documenting/printing growth charts

1. In HealthMatics EMR, pull a patient's chart and, from the left pane or toolbar, click (Vitals).
2. On the secondary toolbar, click **Growth Charts.**



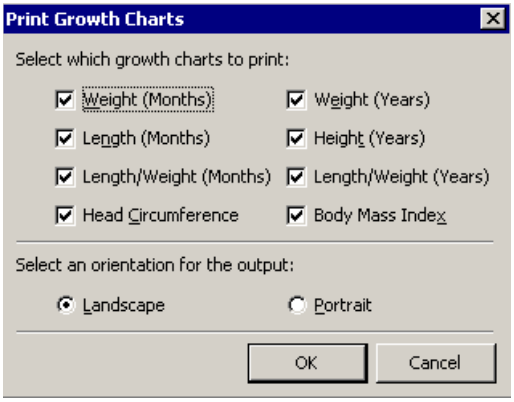
Growth Charts display the third to ninety-seventh percentile lines. You can chart the following:

Age	Chart
1-36 months	• Weight/length • Weight/months • Length/months • Head circumference
2-10 years	• Weight/height
2-20 years	• Weight/years • Height/years • Body mass index

3. To zoom in on a chart, click at the upper left edge of the area that you wish to enlarge, and holding the left mouse button down, drag a box around the area from **left to right**.

NOTE: To return the chart to its original view, click the upper right edge of the chart, and holding the left mouse button down, drag a box from **right to left**.

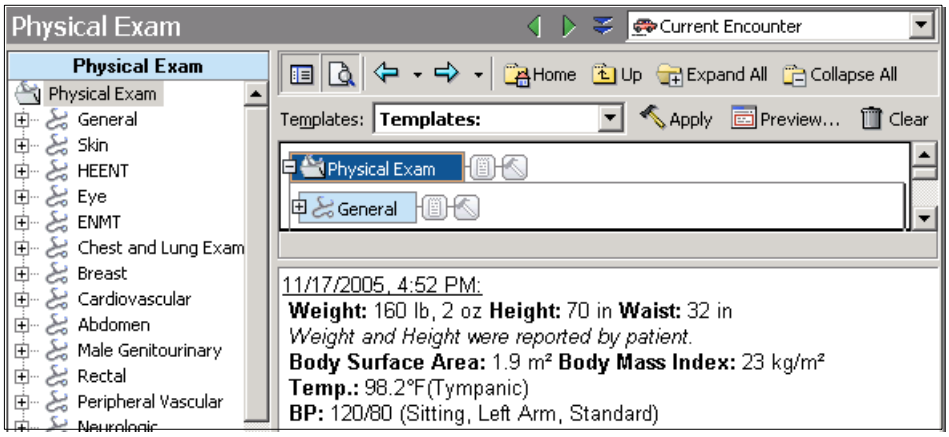
4. To print a growth chart, click **Print** on the toolbar to display Print Growth Charts.



5. Check or uncheck boxes as needed to indicate which growth charts you want to print.
6. Click **OK**.

Viewing vitals in physical exam

Vital signs, height, and weight entered during an encounter also display in the Physical Exam window **below** other findings.



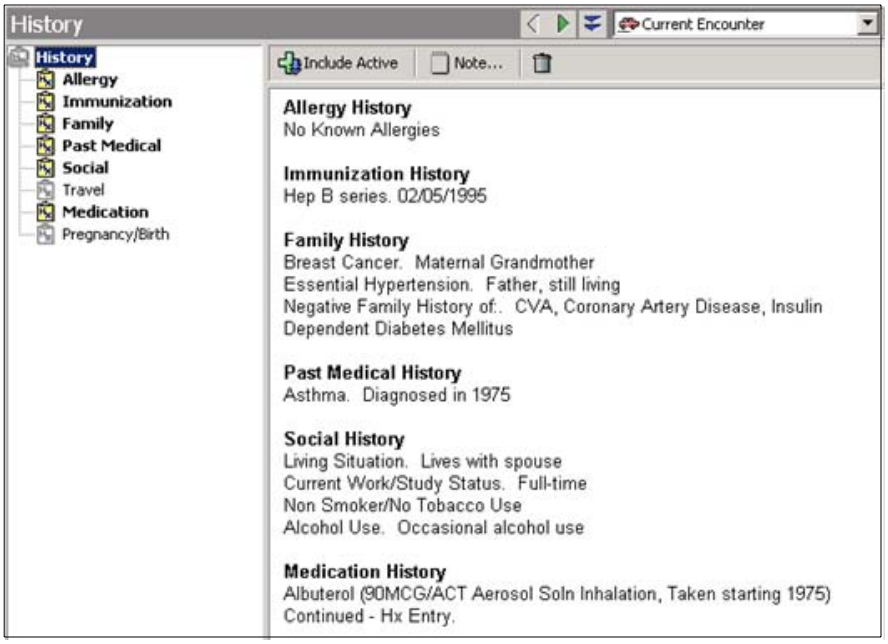
History

Use the History view to document allergies, immunizations, and family, past medical, social, travel, medications, and pregnancy and birth history.

Viewing history during an encounter

At the *History* level in the History view, you can see all items documented during the current encounter.

1. Open a patient chart, and from the left pane or the toolbar, click (History).



NOTE: The folder tree on the left uses colors and fonts to indicate the presence or absence of patient history in previous and current encounters for each category:

- **Yellow** - Folder contains previously entered history
- **Gray** - Folder does not contain previously entered history
- **Bolded font** - Folder contains current encounter data

2. To view current encounter history data, from the *History* folder tree, highlight **History**.
   All items documented in the current encounter display to the right.
3. To create a general history note for an encounter, from the secondary toolbar, click **Note**.
   - Enter general information regarding the patient history on the *Text, Image,* or *Voice* tab.
   - Click **OK** to return to History view.
     The note displays in italics at the end of the History data.
4. To include all previously entered active history items in an encounter:
   - In the left pane of the History view, highlight **History**.

- Click **Include Active**.
  All active history items (in all eight categories) from previous encounters are added to the current encounter.

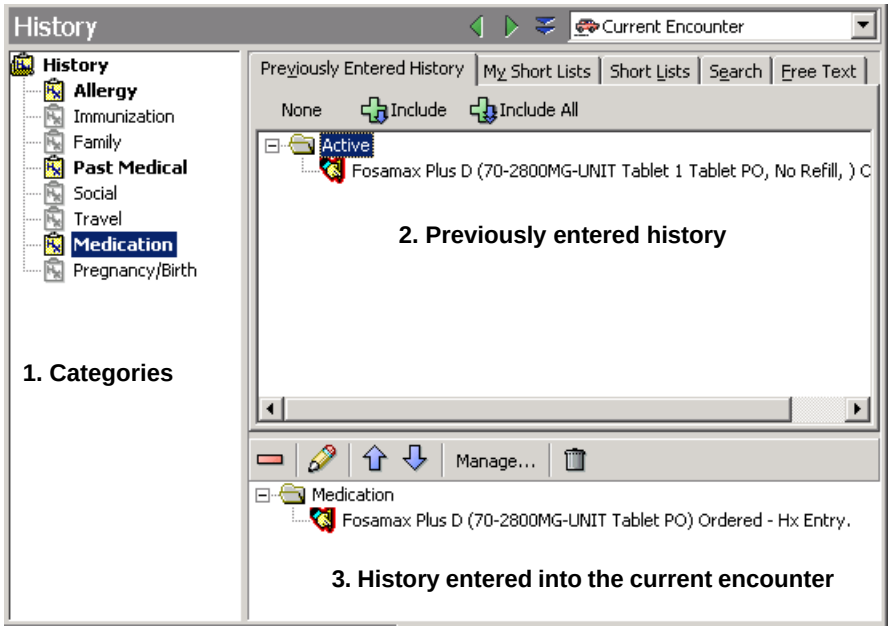
  NOTE: A medication is considered “active” if its status is *Active, Ordered*, or *Continued*.

5. To clear all history items and general notes added to a current encounter, do the following:
   - In the left pane of the History view, highlight **History**.
   - Click to **Clear All** and **Yes** to confirm.

     History items are cleared from the current encounter, as well as any general note (indicated by the paper clip on the **Note** button).

Documenting/adding history from previously entered history

1. Open a patient chart, and from the left pane or the toolbar, click (History).



In the History view, patient information is divided into eight categories (see **1** in the graphic). Enter history information in any of these categories as needed by selecting the category in the left pane and documenting in the right.

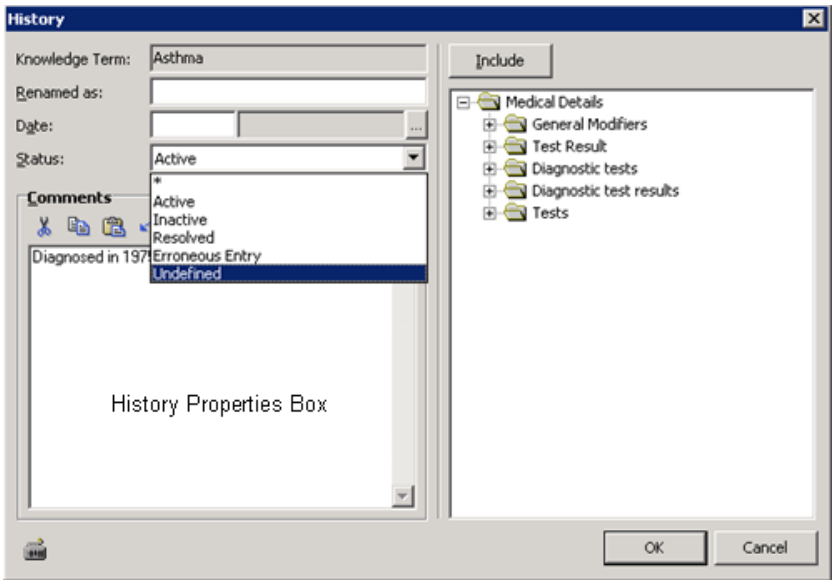
Each category view has five tabs and two panes -- the top pane for displaying previously entered data (see **2**) and the lower pane for history added during the current encounter (see **3**).

Exceptions:
Allergy History does not have a Free text tab because this would interfere with drug interaction checks, and
Immunization History only has two tabs due to the implementation of the Immunization Record.

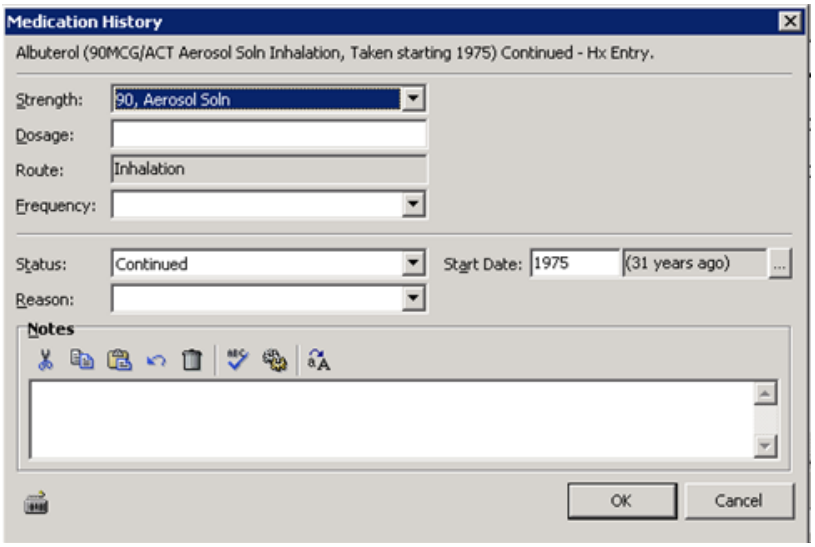
2. In the *History* folder tree, select a category and click the **Previously Entered History** tab.
3. **To add individual items** to the current encounter, do any of the following:
   - Double-click an item ***or***
   - Highlight an item and click **Enter** ***or***
   - Select an item and click **Include** ***or***
   - Right-click and choose **Include** ***or***
   - Click and drag an item from the upper pane to the lower pane
4. **To add all active items** to the current encounter, highlight *Active* and click **Include All** ***or*** (**Shift + Enter**) ***or*** click and drag the **Active** folder from the upper pane to the lower (current encounter) pane or highlight *Active* and click **Enter**.

Editing current encounter history items

1. Open a patient chart, and from the left pane or the toolbar, click (History).
2. In the *History* folder tree, select the category of the item.
3. Enter a history item into the current encounter (see Documenting/adding history from previously entered history on page 248).
4. From the current encounter pane at the bottom of the screen, double-click the item you want to edit ***or*** select it and click (Edit selected item).
   Right-click and choose edit or highlight and press **F2**



NOTE: Medication History displays if a medication is selected.



The *Status* field allows you to change the status of the medication, and then select the *Reason* and include *Notes*. If you select a *Status* of *Discontinued*, an *End Date* field displays for the date the medication ended.

5. Edit items as needed and click **OK**.
   Changes display in the documentation pane at the bottom of the window.
6. To view all changes made, select *History* in the folder tree on the left and view the text changes in the pane on the right.

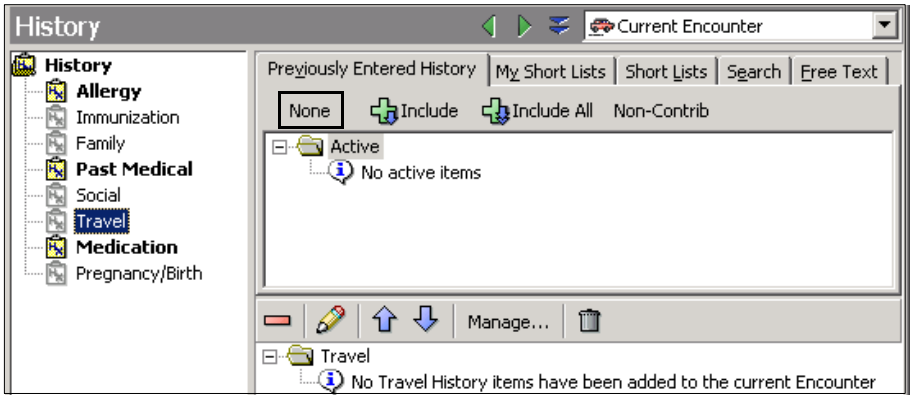
Removing history items from current encounters

1. Open a patient chart, and from the left pane or the toolbar, click (History).
2. To clear all history entries from the current encounter, select the History folder, click , then at confirm, click **Yes** to clear all history items added for the current encounter.
3. To remove history items, from a history category for the current encounter (bottom pane), do **one** of the following:
   - Select the History category and item, click (Delete selected item) then **Yes** to confirm ***or***
   - Click (Clear all items) and **Yes** to confirm to clear all history items from the encounter.

     NOTE: If you select the top-level folder (Allergy, for instance), and click , it performs the same functions as and removes all items from the current encounter.

Indicating no history is available or exists

1. Open a patient chart, and from the left pane or the toolbar, click (History).
2. In the *History* folder tree, select a category that is **not** bolded (indicating it has no history documented in it).



NOTE: Informational messages ( ) display in both the history pane and the current encounter pane.

3. To document the patient has no history in that category, click **None** to replace the informational message with the word, *None*.

   Example: To indicate a patient has not traveled, select the category Travel, and click **None**. When you then highlight History in the folder tree, the documentation shows the following: **Travel History** - *None*.

Including past medical history in current encounters

1. Open a patient chart, and from the left pane or the toolbar, click (History).
2. In the *History* folder tree, select **Past Medical** and the **Previously Entered History** tab.
3. To include all *Previously Entered History* items in the current encounter, do either of the following:
   - Select a folder (**Example:** *Active*) and drag it to the bottom pane ***or***
   - Select the *Active* folder and click **Include All**.

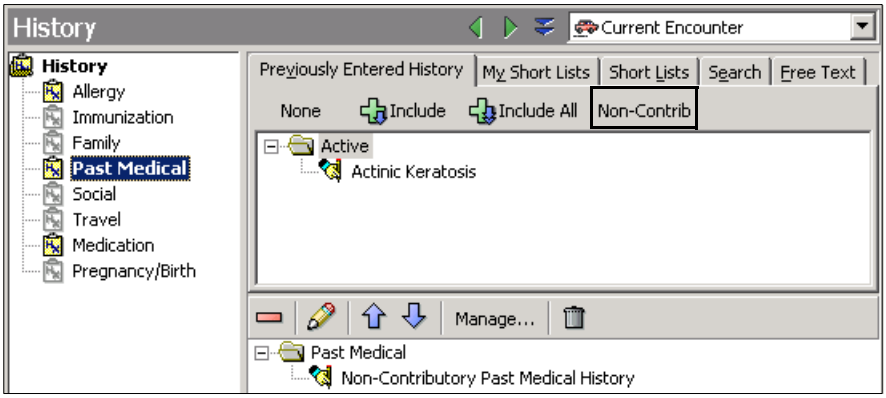
NOTES

- If you plan to manage diagnoses from PMH for use in A/P, use ICD-9 entries to document PMH. This assists billing. (See Managing problem and medication history on page 255.)
- **Erroneous entries** - Any items previously marked *Erroneous Entry* will display under a separate folder in the upper pane. However, this folder is not opened in the History window by default, and erroneous items in it are **not** included in the current encounter if you click **Include All**.
- **Diagnoses**

> **Editing** - If you select a diagnosis in the current encounter pane and click (Edit selected item), the History dialog box appears, which allows you to edit the *Status* of a problem.

Indicating history is non-contributory to current problem

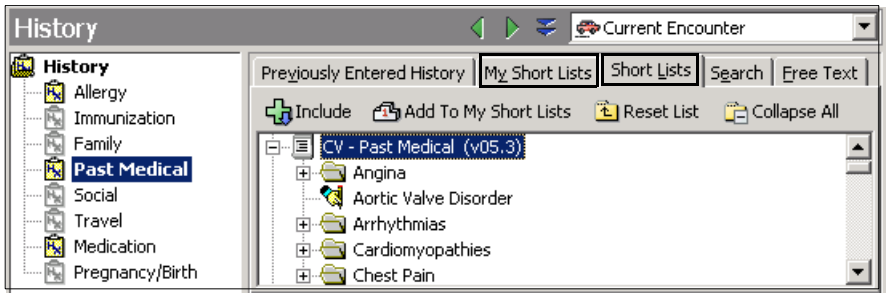
If in a *History* category, no previously entered history contributed to the current problem, indicate that by clicking **Non-Contrib**.



NOTE: You can add other items in the same history category. However, the *Non-Contributory* statement pertains to the **category** and applies to **all** items in the category.

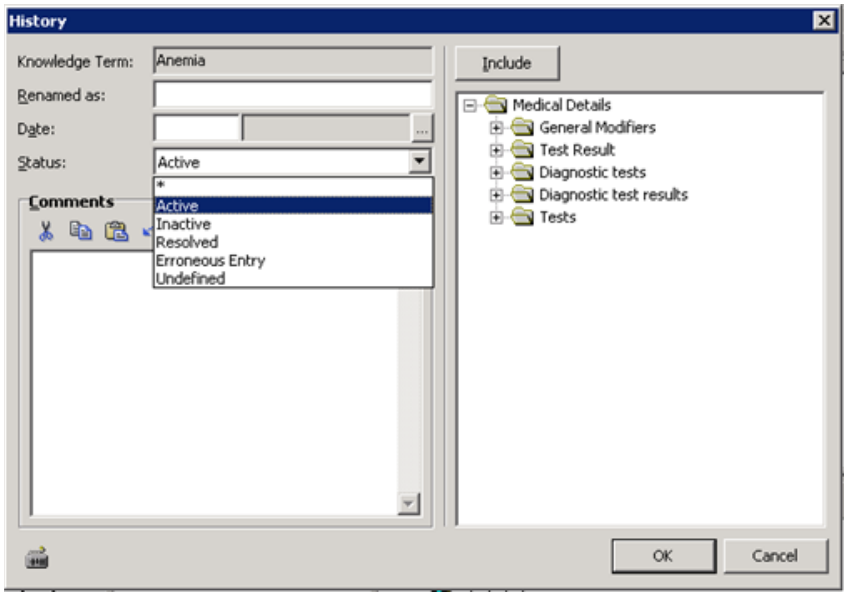
Documenting history using short lists

1. Open a patient chart, and from the left pane or the toolbar, click (History).
2. From the *History* folder tree, select any category except *Immunization* to display the tabs for selecting information.
3. Click the **My Short Lists *or* Short Lists** tab.



4. Click (**+**) as needed to expand folders to locate the item you want to document.
5. Double-click the item ***or*** select it and click **Include *or*** drag it from the upper to the lower pane to display History.

6. Access the properties box by highlighting the item then clicking **Edit *or*** by double-clicking the item and then complete the fields.



Field	Action
Renamed	Leave this field blank to accept the Knowledge Term description ***or*** Rename the term by entered a new name.
Date	Enter a Date. (See Entering dates on page 10.)
Status	Click down-arrow to select a status for the history item: Active, Inactive, Resolved, Erroneous Entry, or Undefined.
Comments	(Optional) Enter free text about the history item.

7. In the right pane, click (**+**) signs to expand the folders as needed to locate history details.
8. Add as many history detail items as needed to the *Comments* box by doing any of the following:
   - Double-click the appropriate detail for the *Knowledge Term* selected.
   - Select the leaf level item and click the *Include* button at the top of the box.
   - Click and drag the leaf level item to the *Comments* box on the left.

   NOTE: Only items that display in the *Comments* box are included in the history note for the current encounter.
9. Click **OK** to save the new information to the current encounter.

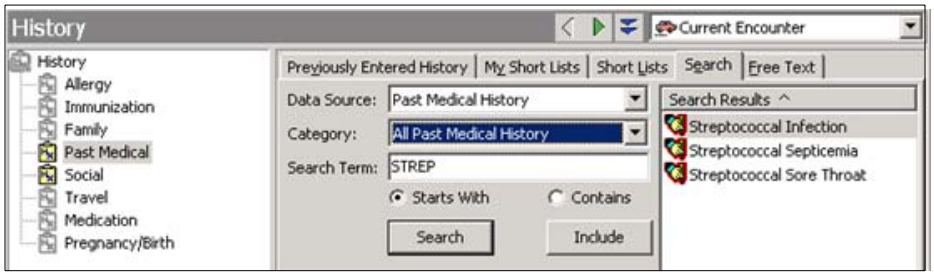
NOTES

- The items you select display in the current encounter pane at the bottom of the History window.

- To see documentation for all categories, highlight *History* in the folder tree on the left.

Documenting history using search

1. Open a patient chart, and from the left pane or the toolbar, click (History).
2. In the *History* folder tree, select any category (except *Immunization)* to display the tabs for selecting information.
3. Click the **Search** tab.At *Data Source*, click the down-arrow to select the



appropriate data library.

NOTE: Data sources available depend upon the category selected in the *History* folder tree.

4. At *Category*, select a category if you want to narrow your search.
5. At *Search Term*, type a few letters of the item you want to find and click **one** of the radio buttons:
   - **Starts with** - To search for items that **begin** with the letters you specified
   - **Includes** - To search for items that **contain** the letters you specified
6. Click **Search** to display the first 100 items in the *Search Results* box.

   NOTE: If more than 100 items fit your search criteria, a message says *Only the first 100 results were returned. For better results, please refine your search criteria.* Enter more specific information for your search criteria and search again.
7. To include history items in the patient's current encounter, do **one** of the following:
   - Double-click the item in the *Search Results* box ***or***
   - Click the item you want to include, then click **Include *or***
   - Drag the item from the *Search Results* pane to the current encounter pane.

Documenting history using free text

You can enter and reuse *Free Text* entries.

1. At *Description*, type the free text entry, ***or***
2. Click **Include** or press **Enter** key.

NOTE: Free text data is not reportable or billable.

Managing problem and medication history

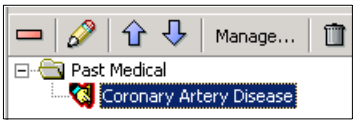
You can add an item from the current history pane to a patient problem or medication list. A red glow around the icon indicates the item is managed.

NOTE: If you build your Past Medical History list from commonly used ICD-9 codes, “Managing” a PMH problem in A/P will be supported by billing. If you do not use ICD-9 codes to build PMH, most likely (unless you have customized otherwise) the problem does **not** have an associated ICD-9 code needed for billing, and could result in rejected claims.

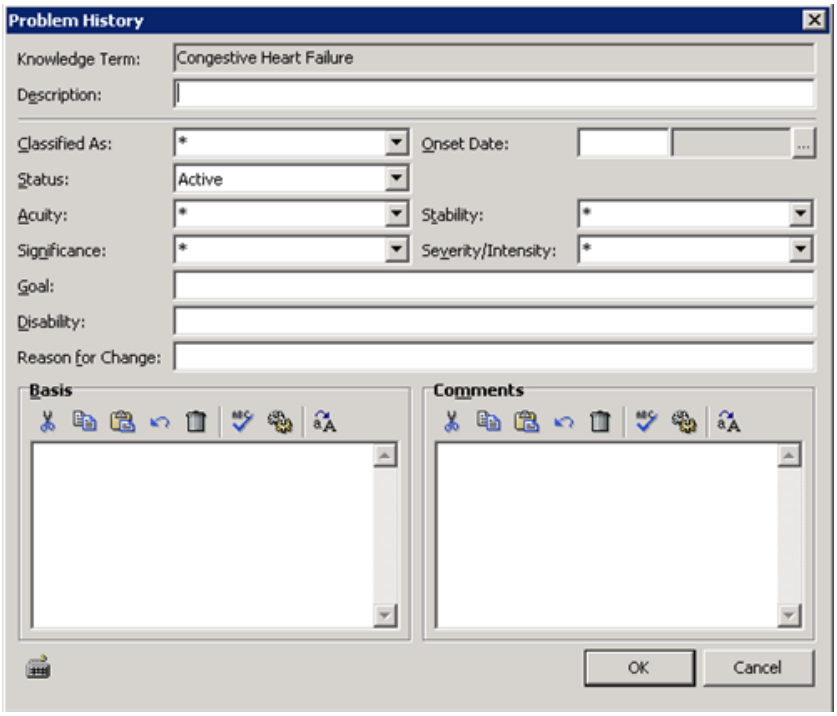
Example: Hypertension may be a historical **and** an active problem, but if added from Past Medical History to the active problem list (rather than in A/P), it will not associate with the ICD-9 code needed for billing (unless you have customized otherwise). This applies with or without a billing interface.

To manage a history item to a patient active problem list, follow the steps below:

1. Open a patient chart, and from the left pane or the toolbar, click (History).
2. In the *History* folder tree, select the category of the item you want to add to the problem list.
3. In the current encounter pane at the bottom of the screen, click **Manage** and **Yes** to confirm.
   A red “glow” displays around the icon hand indicating you have managed the problem or medication.



4. To manage the problem history, once again select the history item in the current encounter pane and click **Manage**.



5. Change history information or add notes as needed and click **OK**.
Changes made or information added display as part of the current encounter in the H&P Report ( ).

To manage medications from history

See also Managing problem and medication history on page 255.

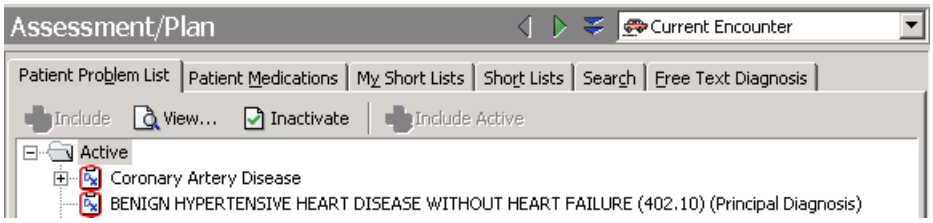
When managing medications, keep the following in mind:

- If you add a medication from a *Short List* or a *Data Source* search, it is initially entered as an historical entry and will not display on the Assessment/Plan screen. As with diagnoses, in order to have the medication display on the Assessment/Plan *Patient Medications* tab, you must click **Manage**. A red “glow” surrounds the icon hand to indicate it is being managed.
- *Free Text* medications cannot be managed.
- If you select a medication already being managed and click **Manage**, a message informs you of that fact. You cannot edit the properties of a medication using the **Manage** button as you can for a diagnosis.
- Once a medication (or diagnosis) has been “managed,” it immediately becomes part of the chart. Even if the associated history item is deleted from the current encounter, the item designated as “managed” will still be part of the chart.
- If a managed item is edited on the History screen, but **not** included on the Assessment/Plan screen, when the next encounter is started, the item that displays on the *Previously Entered History* tab will have the properties of the Assessment/Plan entry, **not** the changes that were entered in History during the

previous encounter. *In other words, in the case of managed items, the properties of the Assessment/Plan entries always override the properties of History entries.*

To view managed history items on the assessment/plan screen

Open a patient chart, and from the left pane or the toolbar, click **A/P** (Assessment/Plan).



Managed items added in History display as child nodes (indented) under the parent entries. History entries are expanded initially if any of the following are true:

- **Medications** - The *Strength* or *Status* of the drug differs from the Assessment/Plan entry.
  Example: The Assessment/Plan medication has an Ordered status, but the medication was marked Discontinued on the Hx screen or the strength was 500MG in Assessment/Plan but the Hx entry was changed to 750MG.

  NOTE: Changes in *Dose* or *Frequency* do not trigger the node to be expanded initially.
- **Diagnoses** - The *Status* was changed.
  Example: The Assessment/Plan diagnosis is Active, but it was marked Resolved in the History screen.
- **History** - An item was marked *Inactive*, *Resolved*, or *Erroneous* in History, on the Assessment/Plan screen. It displays the status after the caption.
  Example: Asthma - Erroneous Entry.

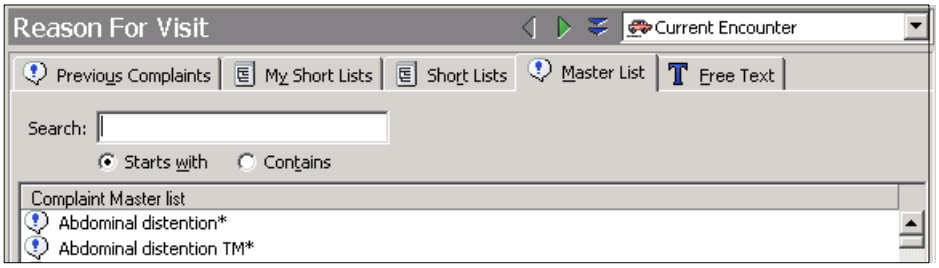
NOTE: You can add the Assessment/Plan entry or the Hx entry to the current Assessment/Plan encounter, but not both. When you add a Hx entry to the current encounter, the *Status* is automatically changed to *Active*.

Reason for Visit

Use the Reason for Visit view to document a patient chief complaint or reason for visit, as the patient reports them.

Documenting reason for visit

Open a patient chart, and from the left pane or the toolbar, click (Reason for Visit).



Complaints can be set up and customized by gender and/or the following age groups:

- Newborn - less than one year old
- Pediatric - less than 18 years old
- Maternal - females 12-55 years old
- Adult - 15 years and older
- Geriatric - 65 years and older

To customize complaints by age group, refer to your HealthMatics EMR ***Clinical Customization*** manual. Customization by gender or age will affect the complaints available for selection based on the patient chart pulled.

To locate the chief complaint or reason for the patient visit, select one of the five tabs near the top of the screen.

To document reason for visit using previous complaints

In Reason for Visit, *Previous Complaints* lists the patient's previously reported problems (CC/HPI). To document the reason for visit using *Previous Complaints*, follow the steps below:

1. Open a patient chart, and from the left pane or the toolbar, click (Reason for Visit).
2. Click the **Previous Complaints** tab to display the patient's *Past complaints list* (CC/HPI) and click a complaint to select it for the current encounter.
   It displays in the *Exams/Complaints* pane at the bottom of the screen.
3. To enter complaint details, select the item in the *Exams/Complaints* pane and do **one** of the following:
   - Press **F2** on your keyboard ***or***
   - Double-click the item ***or***
   - Click (Describe selected item) to display Complaint Details ***or***

- Right-click and select **Describe**.

4. To document Complaint Details, see Documenting complaint characteristics and details on page 262.

   NOTE: If you select a previous complaint that includes free text comments, a message displays when you begin to update the documentation stating the free-text comments will be removed. This message does not refer to text entered in Note fields. Click **Yes** to continue with your documentation. If you do not want to answer this question for subsequent previous complaint documentation, click the *Don't show this message again* checkbox before clicking **Yes**.

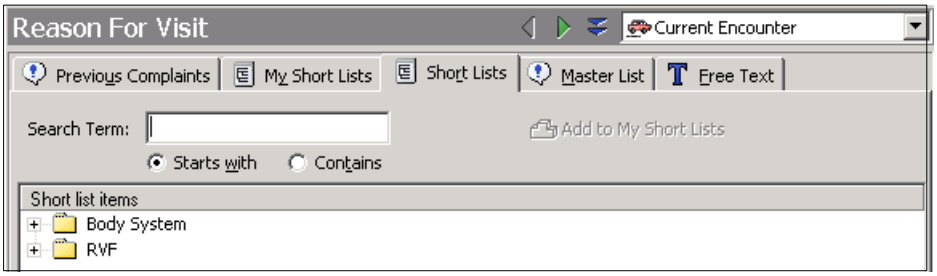
5. Repeat the steps above, if necessary, to document additional previous complaints for the current encounter.

To document reason for visit using my short lists or short lists

The process for documenting reason for visit using *My Short Lists* or *Short Lists* is identical except for the tab that you click.

1. Open a patient chart and, from the left pane or the toolbar, click (Reason for Visit).

2. Click the **My Short Lists *or* Short Lists** tab.



3. At *Search Term*, search for the list as follows:

   - Type a few characters of the list for which you are searching.
     The list filters as you type.
   - If you do not find the list, click **Contains** to search for lists that contain the letters you typed.

4. When you find the list, click the (**+**) to display the complaints it contains.

5. Click a complaint to use it as the reason for visit.
   The item is bolded and also displays in the *Exams/Complaints* box in the bottom pane.

   NOTE: Double-click the complaint to select it and open the Details box at once.

6. To enter complaint details, select the item in the *Exams/Complaints* list and do **one** of the following:

   - Press **F2** on your keyboard ***or***
   - Double-click the item ***or***
   - Click (Describe selected item) ***or***

- Right-click and select **Describe**.

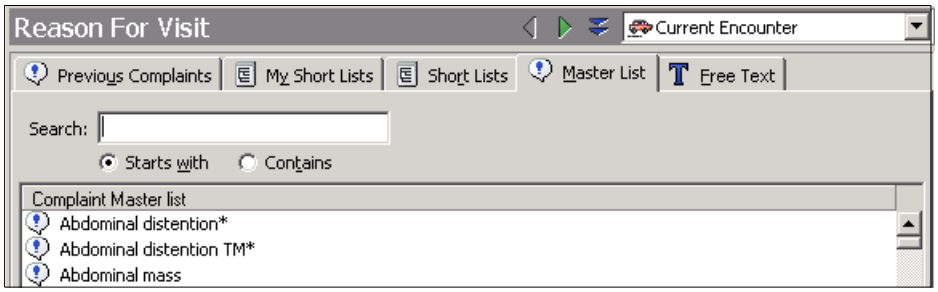
7. To document Complaint Details, see Documenting complaint characteristics and details on page 262.
8. Repeat the steps above, if necessary, to document additional complaints for the current encounter.

NOTES

- Short lists with hot links to disabled short lists display a warning balloon indicating the linked list is not available.
- Short lists in which the description of the chief complaint was changed use the original description when generating text. The original complaint name also displays bolded in the Master list or any other place it is used. To prevent this, add the changed complaint to your short list. Refer to the HealthMatics EMR ***Clinical Customization*** manual for assistance.

To document reason for visit using the master list

1. Open a patient chart, and from the left pane or the toolbar, click (Reason for Visit).
2. Click the **Master List** tab.

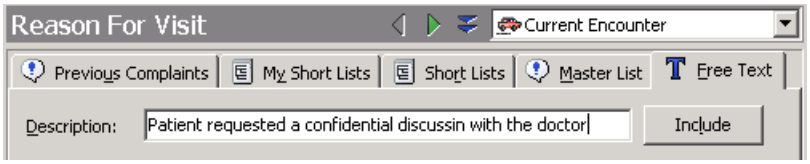


3. At *Search Term*, do the following:
   - Type a few characters of the complaint you need for documentation. The list filters as you type.
   - If you do not find the item you are looking for, click **Includes** to include items that contain letters you typed.
4. When you find the item, click it to use it as the reason for visit.
   The item is bolded and also displays in the *Exams/Complaints* list in the lower left corner of the Reason for Visit screen.
5. To enter complaint details, select the item in the *Exams/Complaints* list and do **one** of the following:
   - Press **F2** on your keyboard ***or***
   - Double-click the item ***or***
   - Click (Describe selected item) ***or***
   - Right-click and select **Describe**.

6. To document Complaint Details (see Documenting complaint characteristics and details on page 262).
7. Repeat the steps above, if necessary, to document additional complaints for the current encounter.

To document reason for visit using free text

1. Open a patient chart and, from the left pane or the toolbar, click (Reason for Visit).
2. Click the **Free Text** tab.



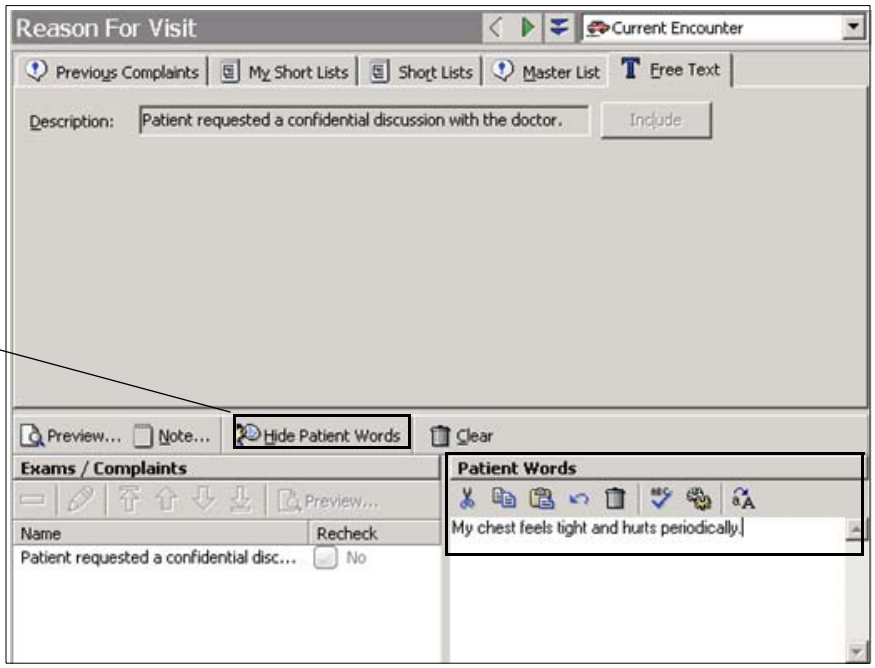
3. At *Description*, enter up to 255 characters of free text to describe a complaint, and then click **Include**.

NOTES

- An encounter can only have one free text entry. If a free text complaint has already been entered in the encounter, the *Description* box displays the name (read only) and the **Include** button is disabled.
- If you make an error in the free text entry, select the entry in the *Exams/ Complaints* box, click (Delete), and then re-enter the free text *Description*.

To document reason for visit using patient words

1. Open a patient chart, and from the left pane or the toolbar, click (Reason for Visit).



Toggles between Show Patient Words and Hide Patient Words

2. Click anywhere in the *Patient Words* text box and type the patient description of the complaint.

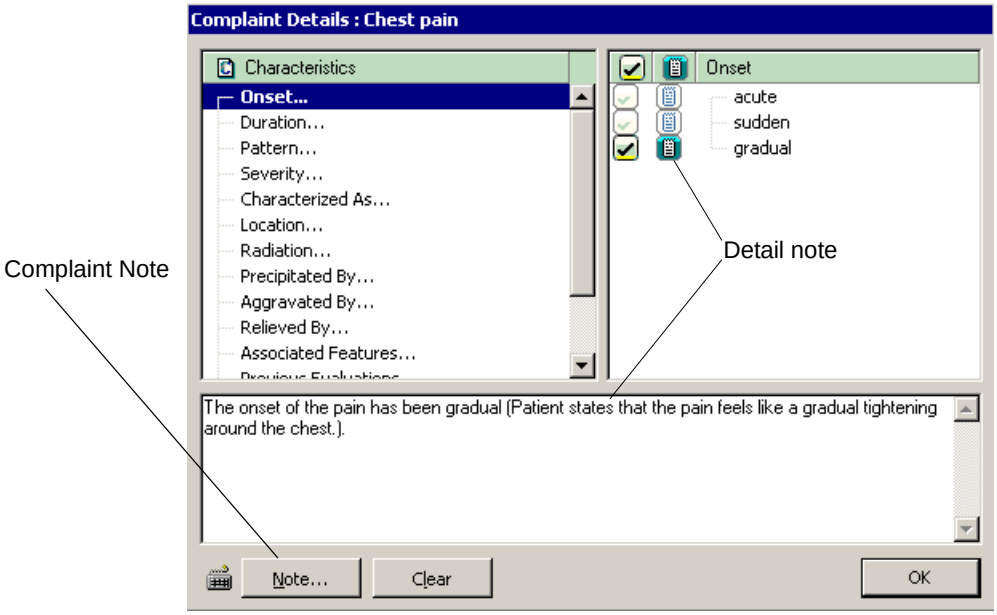
NOTES
* Standard word processing functions, including Cut, Copy, Paste, Undo, Clear, Spell Check, Spell Check Options, and Auto Replace Options all work in this dialog box.

* If the *Patient Words* box is not visible, click Show Patient Words in the center of the Reason for Visit view. This is also a caregiver option setting.

Documenting complaint characteristics and details

1. With a patient chart open in HealthMatics EMR, from the left pane or the toolbar, click (Reason for Visit).
2. Select one or more complaints, pulling from any of the five tabs.
   For instructions, see the following:
   - To document reason for visit using previous complaints on page 258
   - To document reason for visit using my short lists or short lists on page 259
   - To document reason for visit using the master list on page 260
   - To document reason for visit using free text on page 261
3. To enter complaint details, select the complaint in the *Exams/Complaints* list and do **one** of the following:

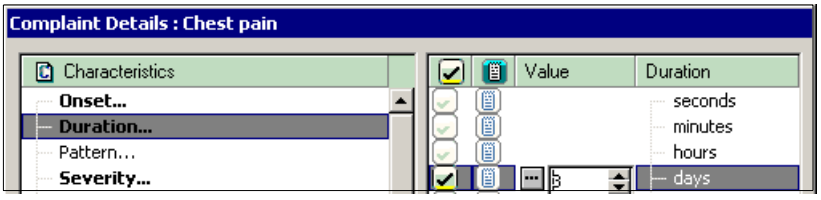
- Press **F2** on your keyboard ***or***
- Double-click the item ***or***
- Click (Describe selected item) ***or***
- Right-click and select **Describe**.



4. Highlight a *Characteristic* for the complaint and, in the right pane, select the detail(s) that describes it.
5. After documenting the detail(s) for one characteristic, click another *Characteristic* for the complaint and continue documenting.
   Values are saved automatically.
6. Click **OK** to return to Reason for Visit.

NOTES

- **Undoing** - To undo or remove a detail while documenting, click the check box again to deselect it. The check box grays out and the corresponding text is removed from the documentation.
- **Numbers** - If you document *Duration* or any other characteristic set to accept numeric entries, when you select an increment (such as *hours*), a search icon displays in the *Value* column.

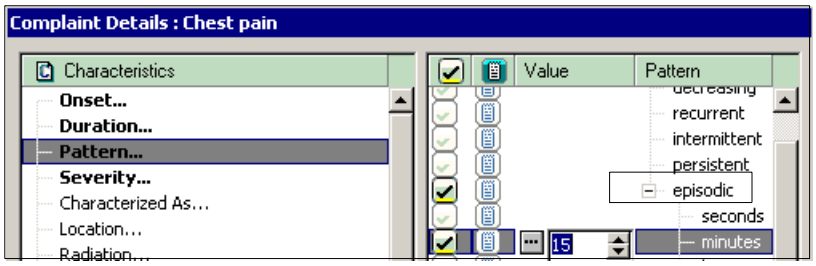


Click to display a number field. Type a number ***or*** click spin-arrows to document the number.

NOTE: Minimum and maximum values for the number are preset in complaint

editor. See the HealthMatics EMR ***Clinical Customization Manual*** if these need to be changed.

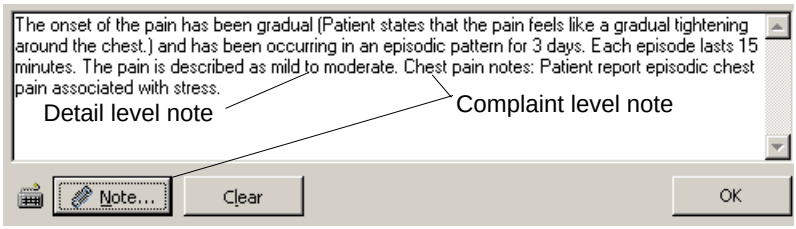
- **Episodic pattern**



To document an episodic pattern, click on the episodic descriptor (**Examples:** seconds, minutes, hours), then click ... to display a number field. Type a number ***or*** click spin-arrows to document the episodic pattern.

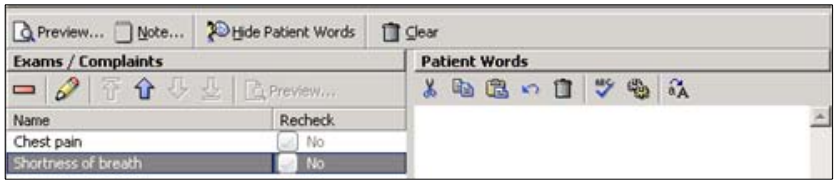
- **H&P report** - The text in the *Text* box changes as you document characteristics and details. This text is automatically added to the H&P Report. If the complaint is the only complaint or is the first complaint documented, an additional sentence documenting this is added to H&P.
- **Add notes** - You can add additional text to the documentation at both the complaint and detail levels.

  > **Complaint level** - Click **Note** at the bottom of the screen. Type the note and click **OK**. A paper clip displays on the **Note** button and the text displays in the bottom pane at the end of the complaint details.


The onset of the pain has been gradual (Patient states that the pain feels like a gradual tightening around the chest.) and has been occurring in an episodic pattern for 3 days. Each episode lasts 15 minutes. The pain is described as mild to moderate. Chest pain notes: Patient report episodic chest pain associated with stress.
Detail level note
Complaint level note
Note...
Clear
OK

  > **Detail level** - To add a note about the detail, click ... next to the selected item. When a note is entered, the note icon is highlighted and the text of the note displays in parentheses in the bottom pane beside the detail the note applies to.

- **Review/sort documentation** - The tools in the lower left corner of the Reason for Visit screen allow you to review, edit, delete, or sort the text of your documentation for the encounter at any time before signing off on the patient H&P Report.



Use the icons to do any of the following:

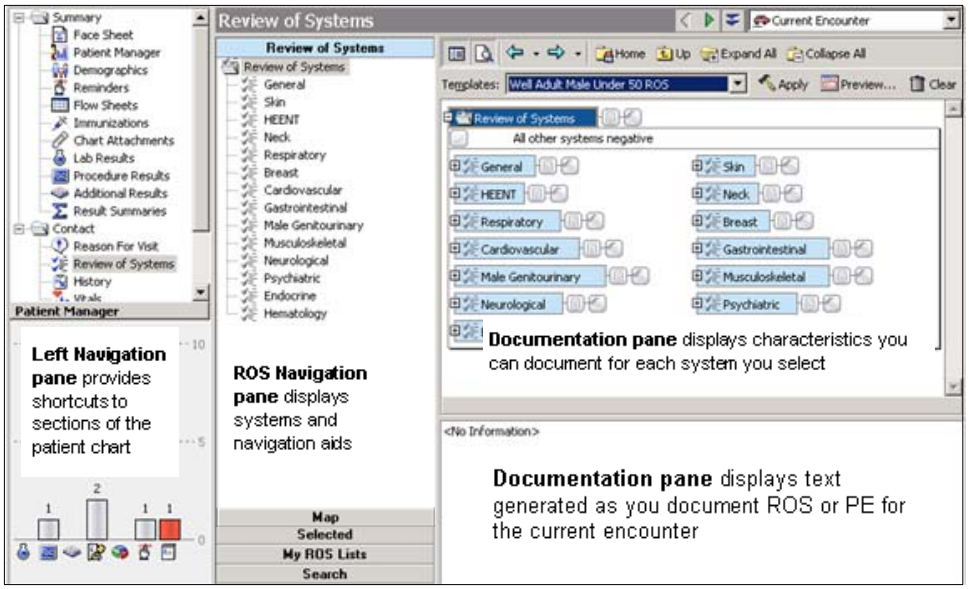
Icon	Name	Action
	Preview - Show HP text	Click to show all complaint text generated for Reason for Visit.
	Add or edit reason for visit note	Click to insert a Reason for Visit note. When a note is added icon changes color to .
	Hide/show patient words	Click to *Hide Patient Words* text (and box) from the H&P. Click again to *Show Patient Words*.
	Clear all items	Click to clear all items in Reason for Visit.
	Isabel	Click to access Isabel, a web-based decision support system (purchased module).

In the *Exams/Complaints* box, select a complaint and right-click for a menu or click an icon to do any of the following tasks:

Icon	Name	Action
	Remove selected item (**Del**)	Click to remove selected complaint.
	Describe selected item (**F2**)	Click to describe the characteristics and details of the selected complaint.
	Move first	Click to move complaint to the primary spot.
	Move up	Click to move complaint up one.
	Move down	Click to move complaint down one.
	Move last	Click to move complaint to last spot.
	Preview Text	Click to preview the text for a selected exam/complaint.

ROS and PE Navigation

To access the Review of Systems screen or the Physical Exam screen, open a patient chart and, from the left pane or the toolbar, click either (ROS) or (PE).



Review of Systems (ROS) and Physical Exam (PE) both contain the same four panes for easy navigation.

NOTE: The ROS and PE screens support resolutions up to 640x480.

Using the navigation pane in ROS and PE

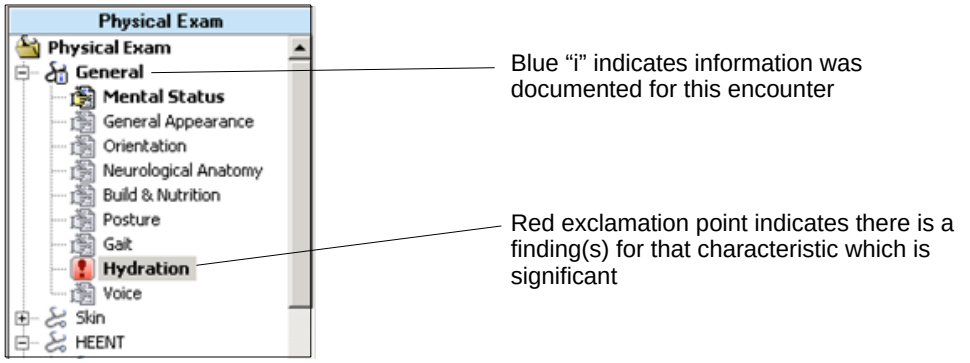
Open a patient chart and, from the left pane or the toolbar, click (ROS) or (PE). See also ROS and PE Navigation on page 266.

The *ROS/PE Navigation pane* in both views includes up to five tabs depending on the settings in caregiver options. The active tab is highlighted.

To navigate using the review of systems (or physical exam) tab

Open a patient chart, and from the left pane or the toolbar, click (ROS) or (PE).

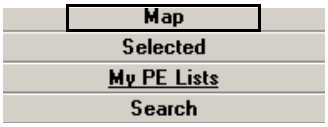
The ROS/PE navigation trees both display systems in a ranked order. Folders that contain documentation display bolded. If a detail within the folder is marked “significant,” the icon turns to a red exclamation point.



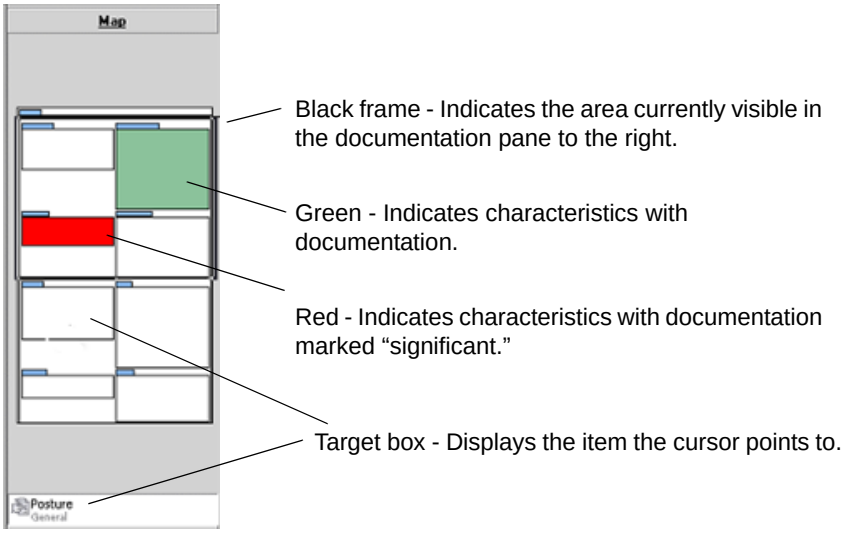
- To expand a folder in PE and show the contents in the documentation pane to the right, click the folder.
- To expand a folder, click (**+**).
- To collapse a folder, click (**-**).

To navigate using the map tab

1. Open a patient chart, and from the left pane or the toolbar, click (ROS) or (PE).
2. In the ROS navigation pane, click **Map** to navigate through the exam using an outline format.



The navigation pane changes from the tree view to a map.

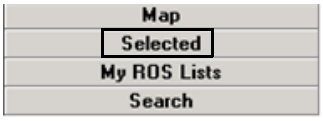

Map
Posture
Black frame - Indicates the area currently visible in the documentation pane to the right.
Green - Indicates characteristics with documentation.
Red - Indicates characteristics with documentation marked “significant.”
Target box - Displays the item the cursor points to.

3. Navigate the map as follows.

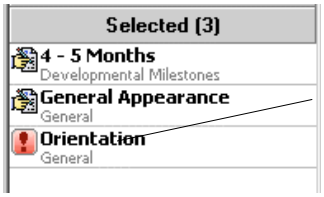
Action	Effect
Click the black box and drag it up and down	Documentation pane scrolls according to the box position.
With the mouse outside the black box, click on a "target"	The "target" characteristic under the cursor displays in the target box beneath the map. Click the item in the target box to display it in the documentation pane.

To navigate using the selected tab

1. Open a patient chart, and from the left pane or the toolbar, click (ROS) or (PE).
2. Apply a template or document items in ROS or PE.
3. In the navigation pane, click **Selected** to navigate through the exam using a selection list of body systems which have documentation.



All characteristics with documentation, display in the Selected list. If any selected items are marked "significant," the characteristic icon changes to a red exclamation point**.**



This characteristic contains a detail that was marked significant.

4. Click a characteristic in the list to display it in the documentation pane on the right and make any necessary updates.

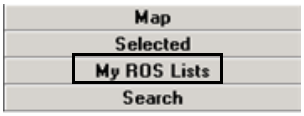
To navigate using the my ROS (PE) lists tab

1. Open a patient chart, and from the left pane or the toolbar, click (ROS) or (PE).

   NOTE: If you frequently use templates for documentation, setting the caregiver option, *Jump to Selected after Apply* will help quickly make changes to your template to document your patient's current condition.

2. In the navigation pane, click **My ROS (PE) Lists** to navigate through the exam using a selection list you can create with the body systems or characteristics that you

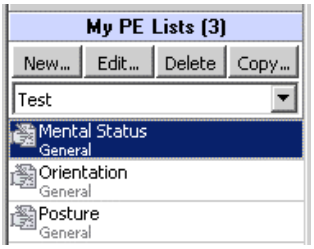
typically document.



NOTE: My ROS/PE Lists are helpful to ensure you document necessary exam bullets for the E&M billing level calculation for the encounter.

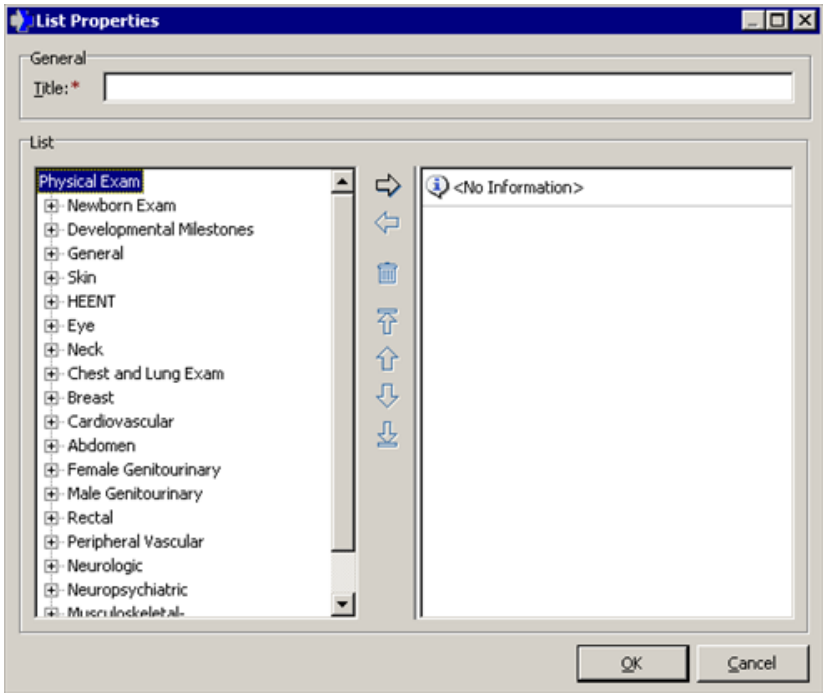
To add exam lists to the my ROS (PE) lists tab

1. From the navigation pane, click **My ROS (PE) Lists**.



NOTE: Information in the documentation pane does not change until a body system/characteristic in the ROS (PE) list is selected.

2. Click **New** to display List Properties.



- At *Title*, enter a name for your personal physical exam list.

3. From the list on the left, select folders or characteristic you want to add to your ROS or physical exam list, then click (or right-click), repeating as needed to add all body system folders/characteristics that you want.

4. To sort the items in your list, select an item and click the icons located in the middle of the screen as needed:

Icon	Action
	Deselects item.
	Deletes all items from the selected list.
	Moves item to the top of the list.
	Moves item up one position.
	Moves item down one position.
	Moves item to the bottom of the list.

5. Click **OK**.

To edit exam lists on the my ROS (PE) lists tab

1. Select the list, then click **Edit**.
2. Use left arrow icon to deselect and move unwanted items out of your list; use the appropriate arrow to sort/rearrange items as desired.
3. Click **OK**.

To delete exam lists on the my ROS (PE) lists tab

1. Select the list.
2. Click **Delete** and **Yes** to confirm.

To copy lists on the my ROS (PE) exam lists tab

1. Click **Copy**.
2. Select a caregiver list to copy and click **OK**.

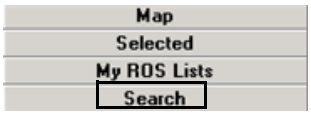
NOTES
* You can copy multiple caregiver lists by pressing down and holding the **Ctrl** key on your keypad and clicking desired lists.

* The copied lists are named (for example) *"copy of Cold."* If the list name exists, a new one is created and **_2** displays following the original list name.

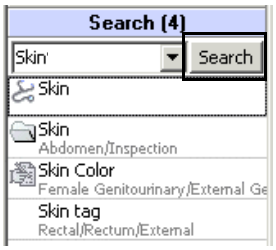
3. Edit the copied list(s) as needed.

To navigate using the search tab

1. Open a patient chart and, from the left pane or the toolbar, click (ROS) or (PE).
2. In the navigation pane, click **Search** to navigate through the exam by searching for items.



.



3. Enter search criteria and click **Search**.
   Search results contain the search criteria you entered, depending on settings you selected in Caregiver Options (see To set review of systems and physical exam defaults on page 119).

NOTES

- The last 10 search terms are saved.
- Select an item in the results list and the documentation pane scrolls to the selected item.

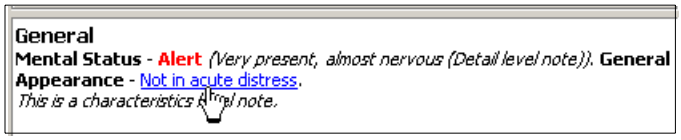
Using the preview pane in ROS and PE

For instructions for navigating in the ROS and PE views, see ROS and PE Navigation on page 266.

1. Open a patient chart, and from the left pane or the toolbar, click (Review of Systems) or (Physical Exam).
2. Document a review of systems or physical exam (see Using the documentation pane in ROS and PE on page 272).

   NOTE: Text generated as you document appears in the preview pane (the lower pane on the right side of both the ROS and the PE views). You can click directly on text in the preview pane to navigate to the item.
3. From the left navigation pane, click **Review of Systems** (or Physical Exam).

4. Move the cursor over text in the preview pane until the cursor changes to a hand and the selected text is underscored or highlighted indicating it is a link.


General
Mental Status - Alert (Very present, almost nervous (Detail level note)). General
Appearance - Not in acute distress.
This is a characteristics detail note.

5. Click the link to navigate to the selected item.

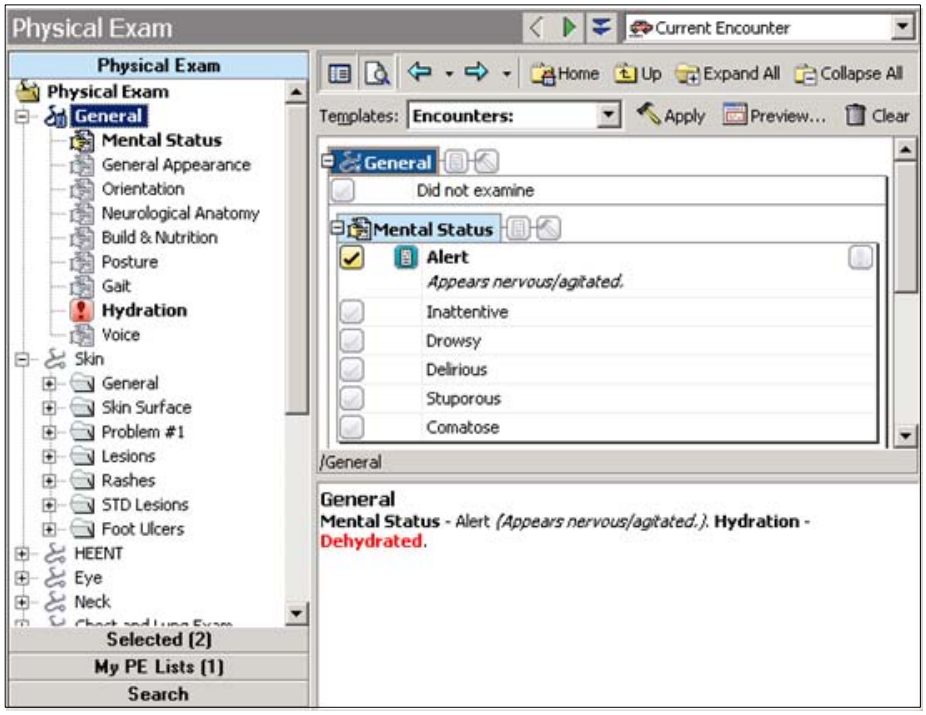
Using the documentation pane in ROS and PE

For instructions for navigating in the ROS and PE views, see ROS and PE Navigation on page 266.

Document characteristics and details of body systems in the documentation pane near the upper right side of both Review of Systems and Physical Exam during a patient visit.

1. Open a patient chart, and from the left pane or the toolbar, click (Review of Systems) or (Physical Exam).

2. Under *Review of Systems* or *Physical Exam*, click a body system to display its characteristics in the documentation pane to the right.
In the example below, the "system," *General*, is selected.

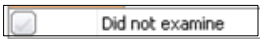
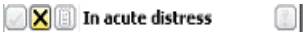
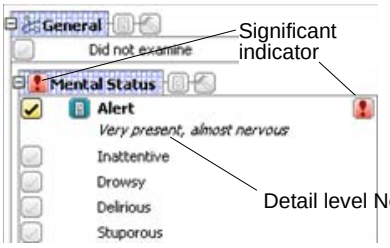


- **Characteristics/details** - System characteristics display in boxes: *Mental Status, General Appearance,* and so forth. Details are listed under each characteristic.

- **Columns** - The number of columns displayed in the documentation pane is controlled in Caregiver Options (see To set review of systems and physical exam defaults on page 119) and depends on the space available.

- **Quick navigation tip** - If the choices displayed in the documentation pane are such that you need to scroll, you can move quickly from one place to another in this pane by clicking anywhere in a white space and dragging the list up or down (a hand displays with this movement).
- **Quick tabbing through values** - Select values quickly by doing either of the following:
  - > Click a detail multiple times to tab through its values (positive, negative, deselected) ***or***
  - > Select a detail, then press the space bar key on your keyboard repeatedly to tab through the values.

3. Select a detail, then do any of the following to document.

Item	Action
Did not examine 	This is the first available option for each body system.
Present 	To indicate the item is present, click the checkbox on the left. The check mark changes colors and the item is bolded. Text displays in the bottom documentation pane.
Not present 	To indicate an item is not present, click the **X** box. • This option is not available for all details.
Significant 	If the presence (or absence) of an item is significant, click the exclamation point box to the far right of the item. The icon turns red and a red exclamation point displays in the characteristic and body system boxes. The item is indicated as significant in all views including the H&P Report. **NOTE:** The exclamation mark only displays once the item is selected.
To deselect an item	Click ☑ or ☒
To change detail status from ☑, ☒, or no detail selection	Click the item caption. The item toggles between the possible statuses.

NOTES

- The text of any note entered displays beneath the detail.
- Click the note text to open a dialog box to view the entire note.
- All notes are saved in the H&P Report and display as follows:

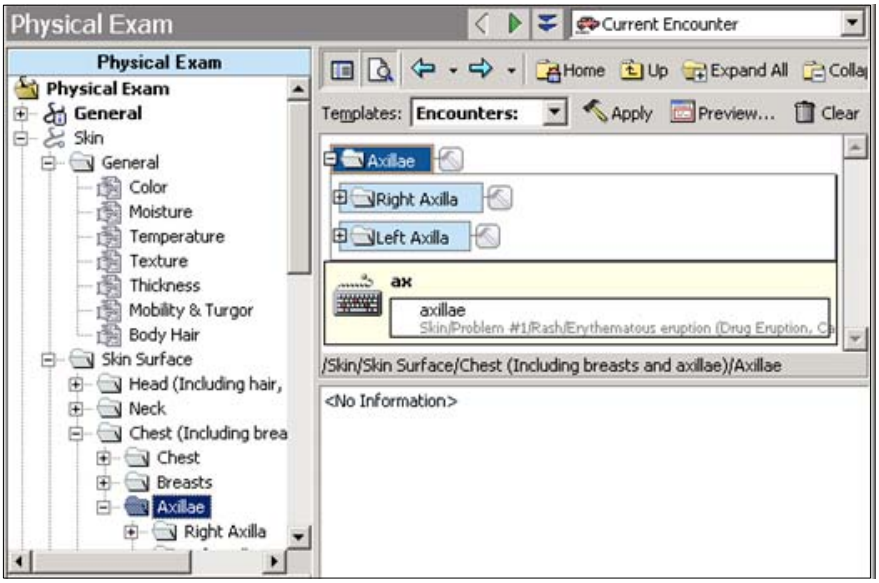
> **ROS or PE level note** - The entire note displays *Italicized* at the top of the preview pane.

> **Characteristics note** - The word ***Note:*** displays before the note and the entire note is *italicized* at the end of the characteristic documentation.

> **Detail note** - The entire note displays *(within parentheses and is italicized)* next to the detail term.

To document using quick search

1. Begin to type a few characters of the item you need with the focus on the top documentation pane.



2. When the desired item displays in a yellow box, click **Enter** on your keyboard to automatically scroll to the selected item.

3. Use the following keystroke conventions with Quick Search:

Key	Action
A.Z. a.z	Type any letter in the documentation pane to start Quick Search and open a yellow box with the item that fits the criteria you entered. Depending on the caregiver option set, *Starts with* or *Contains* is used for the search (see To set review of systems and physical exam defaults on page 119).
ESC	Ends the Quick Search with no action.
Enter	Jumps to the folder or item displayed in the white “target” box under the search string.
/	If your search target is a folder, quick search locates the folder and presents only folder subfolders and items.
F3	Jumps to the next item matching the search term.

NOTE: Quick Search begins searching from the highlighted item down the navigation tree.

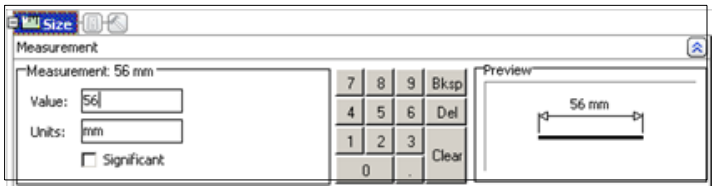
To navigate using key strokes

Key	Action
Home	• If an item is selected, the selection jumps to the folder. • If a folder is selected, selects its parent folder.
Ctrl + Home	Same as toolbar Home.
End	• If on an item, selects the last item in that list. • If on an expanded folder, selects the last subfolder. • If on a collapsed folder, selects the last sibling folder.
Page Up	Moves the focus to physical exam.
Page Down	Moves the focus to the last item in list and opens the item.
Left	• If on an item, moves the selection to its parent folder. • If on an expanded folder, collapses the folder. • If on a collapsed folder, moves the selection to the parent folder.
Alt + Left	Same as toolbar (**History Back**)
Ctrl + Left	If on a folder, its the same as on the toolbar (**Collapse Folder**)
Right	• If on an item, moves to the next possible folder. • If on an expanded folder, moves to the next sibling folder. • If on a collapsed folder, expands the folder.
Alt + Right	Same as toolbar (**History Forward**)
Ctrl + Right	If on a folder, same as toolbar (**Expand Folder**)
(+)	If on an item, selects or deselects (☑)
(-)	If on an item, selects or deselects (☒)
(!)	If on an item that has a value, the significant indicator toggles.
Enter	• If on an item, toggles the value. • If on a folder, navigates the documentation pane to the folder.
Space	If on a item, toggles the value.

To document measurements and sizes

Measurement and size dialog boxes appear when *Measurement Size* is selected as the *Knowledge Flow* for a user-defined term.

1. To document one-dimensional measurement values.



2. **Value** - Click keypad buttons or use keystrokes to enter a value.

   NOTE: Click **Clear** to clear the *Value*.

3. **Preview** - A graphic to the right shows a proportional presentation of the measurement.

4. **Significant** - Click to check the *Significant* box with a red indicator, indicating that the measurement is significant.

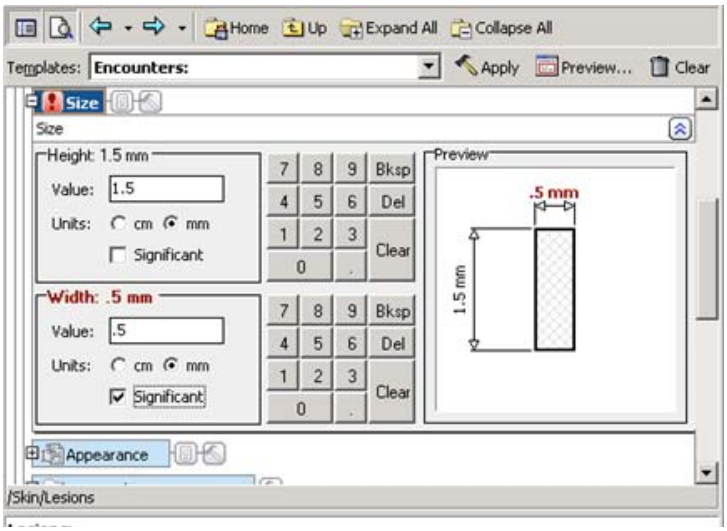
5. **Note** - Click to include a note with the measurement.

6. **Expand/collapse** - To expand or collapse the dialog box, do either of the following:

   - Click the title, Measurement ***or***
   - Click the icon in either upper corner (or).

NOTES

- To document two-dimensional measurement values.

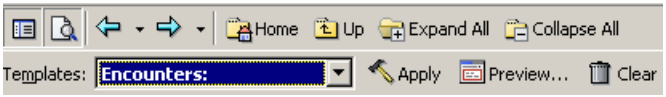


  Enter *Height* and *Width* using the keypad or key strokes. Select the units of measurement in centimeters or millimeters.

- The *Preview* window shows the area proportions, but is not drawn to scale.
- If a value is entered for only the *Height* or the *Width*, the *Preview* graphic is linear, rather than two dimensional.

Using the toolbars in ROS and PE

Open a patient chart, and from the left pane or the toolbar, click (Review of Systems) or (Physical Exam).



NOTE: Most ROS/PE toolbar functions can also be accessed by right-clicking in the documentation pane and selecting the item from the menu that appears.

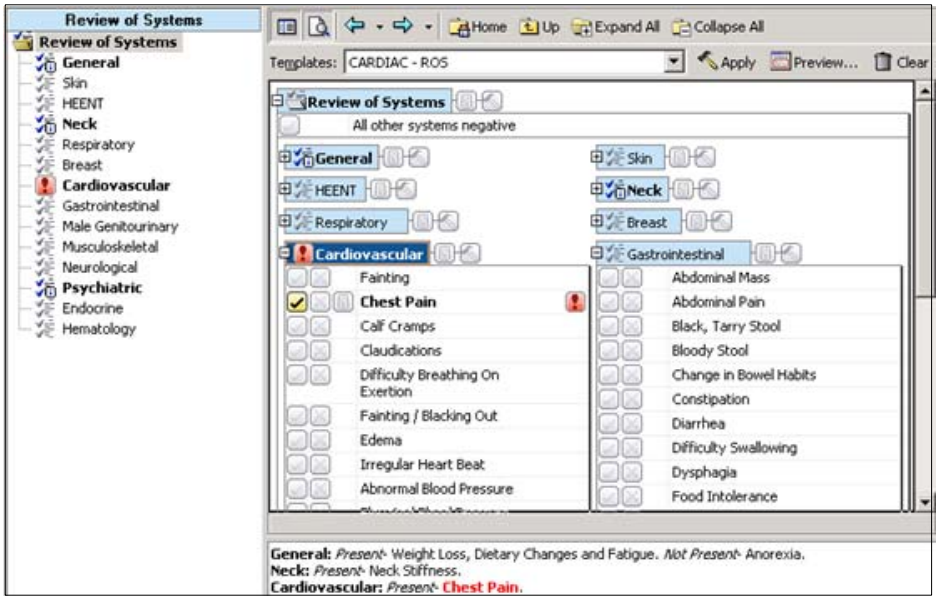
Icon	Name	Action
	Navigation	Toggles the navigation pane on and off. The last settings are remembered for each caregiver.
	Preview	Toggles the preview pane. The last settings are remembered for each caregiver.
	Navigate Back	The view navigates back in history. Click the down arrow to display a menu with a maximum of 20 entries to navigate back to documented items.
	Navigate Forward	The view navigates forward in history. Click the down-arrow to display a menu with a maximum of 20 entries to navigate forward to documented items.
	Home	The navigation tree switches to the top level (that is Review of Systems or Physical Exam). All the child folders are visible.
	Up	The view navigates to the parent folder of the current selection.
	Expand All	From the currently selected folder down, all the child folders are expanded.
	Collapse All	From the currently selected folder down, all the child folders are collapsed except the last level.
Templates	Templates	Click the down-arrow to select a template (exam list) from the drop-down list (see To set review of systems and physical exam defaults on page 119 to set Template options).
	Apply	Click to apply the selected template to the current encounter (see To set review of systems and physical exam defaults on page 119 to set Apply options).
	Preview	Click to preview the values of the applied template.
	Clear	After a confirmation, all the values are cleared from the selected folder down.

Review of Systems

To document Review of Systems (ROS) findings click items for each system. You can document ROS based on templates, previous encounters, or from scratch.

Documenting ROS using templates

1. Open a patient chart, and from the left pane or the toolbar, click (Review of Systems).



2. Click the **Templates** down-arrow and select an item.

   NOTE: You can **Preview** template values prior to applying them to the current encounter ***or*** **Apply** the values directly without previewing.

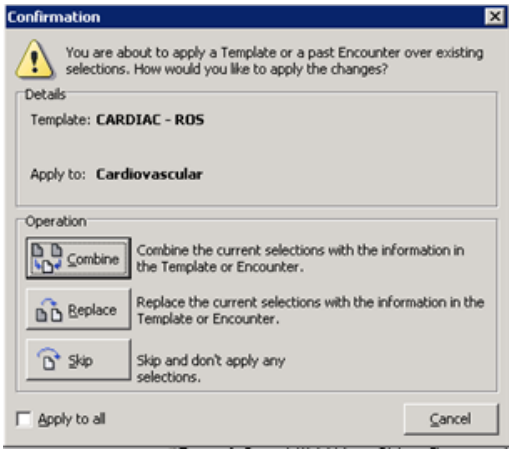
3. To view the values (to ensure you have selected the appropriate template), click **Preview**.

   NOTE: In the Preview pane, click the template down-arrow and view templates until you find the one most appropriate; then click **Apply**.

4. To apply template values to the current encounter, click **Apply** from either the preview dialog box or from the secondary toolbar in the Review of Systems view.

5. **IF** you previously entered values on any of the systems before applying template values, and your *On Apply* default is set to **Prompt** (in **Options > Edit Options > Review of Systems**), the following dialog displays.

.


Confirmation
You are about to apply a Template or a past Encounter over existing selections. How would you like to apply the changes?
Details
Template: CARDIAC - ROS
Apply to: Cardiovascular
Operation
Combine
Combine the current selections with the information in the Template or Encounter.
Replace
Replace the current selections with the information in the Template or Encounter.
Skip
Skip and don't apply any selections.
Apply to all
Cancel

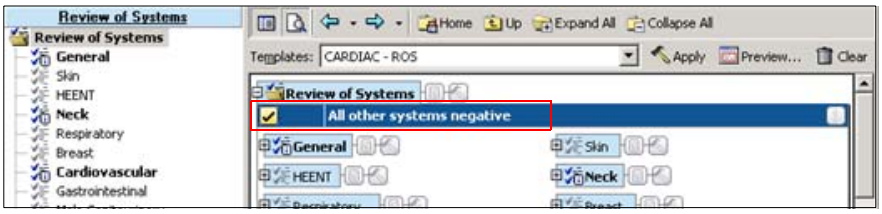
Use the table below to determine which *Operation* to select for each system:

Screen Element	Action
Template	Displays the name of the template selected.
Apply to	Displays the name of the first system that contains previously entered values. When you click one of the three *Operation* buttons, the next system containing values displays after *Apply to* (unless you select **Apply to all** prior to clicking the operation button).
Combine	Click to combine the values previously entered with the template or encounter information for the system indicated in *Apply to*.
Replace	Click to replace the values previously entered with those contained in the selected template or encounter.
Skip	Click to avoid adding the selected template or encounter values to those previously entered for the *Apply to* system shown.
Apply to all	Select to indicate that the operation button selected (**Combine, Replace** or **Skip**) should apply to all systems.

NOTE: In the left pane of Review of Systems, those systems containing values applied display in bold and the documentation generated displays in the lower right pane.

6. Edit template values by doing the following:
   - In the Review of Systems pane, select a (bolded) system.
   - In the documentation pane on the right, view the selections made, and click applicable positives (checks) or negatives (**X**s) to reflect the values for the current encounter.
   - Click the current encounter documentation details to navigate directly to the item you need to change.
7. After documenting pertinent body systems, you can document that findings in all **other** systems are negative.

- In the Review of Systems pane, highlight *Review of Systems*.
- Select the **All other systems negative** box in the right pane (under Review of Systems).



All other systems negative is added to the bottom of your system review.

Documenting ROS using previous encounters

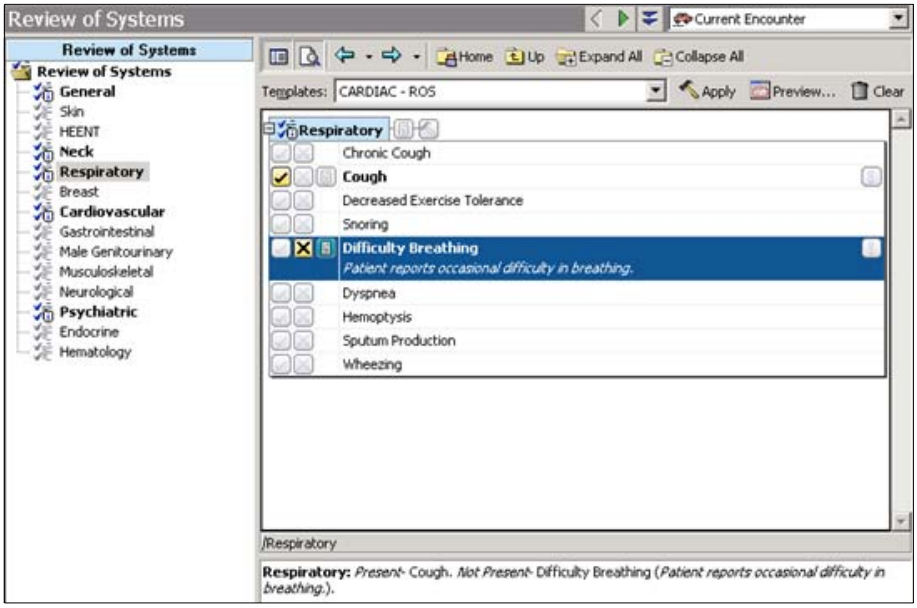
1. Open a patient chart and, from the left pane or the toolbar, click (Review of Systems).
2. Click the **Templates** down-arrow and select a previous visit under *Encounters*.

   NOTES
   * **Encounters** displays **only** if the patient has had Review of Systems documented during previous encounters.

   * The number of encounters listed depends upon the selection made in caregiver options. (See **Options > Edit Options > Review of Systems >** *Past Encounter Count*.)
3. Select an encounter from the list and click **Preview** to preview the values or **Apply** to apply the values to the current encounter (see Documenting ROS using templates on page 278 for details).
4. Make changes to the values as needed, based on your review of patient systems in the current encounter.

Documenting review of systems from the beginning

1. Open a patient chart, and from the left pane or the toolbar, click (Review of Systems).
2. In the *Review of Systems* pane, select a system to review.



3. In the documentation pane on the right, document details by clicking the icons as described in the table below:

Icon	Name	Action
	Present	Indicates the item is present.
	Not present	Indicates the item is not present.
	Note	Indicates a note is present. Click to view the whole note (see Adding review of systems notes on page 282). You can display notes automatically in caregiver options.
	Significant	Indicates the finding is significant.

NOTES
* As icons are clicked, values are documented at the bottom of the screen.
* To deselect an item, click the icon again. The icon turns gray and the documentation is removed.

4. In the *Review of Systems* pane on the left, select another system and repeat the process until all systems are documented as needed.

NOTE: Systems in the left pane display in **bold** as they are documented. The significant findings icon ( ) displays in front of the system in the left pane, and also on the system and detail in the right pane when selected.

Adding review of systems notes

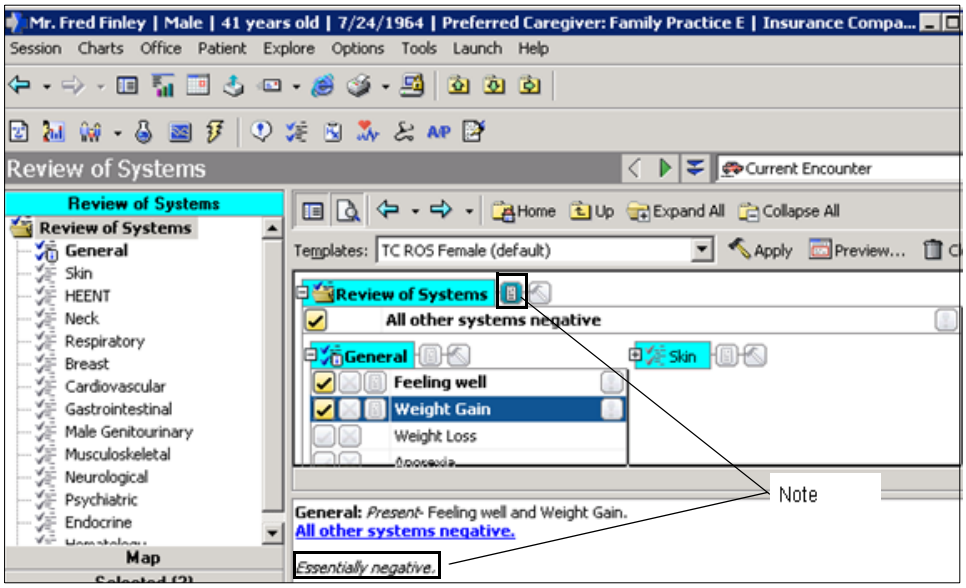
You can add system review notes at three levels.

- Review of Systems
- System
- Detail

To access Review of Systems, open a patient chart and, from the left pane or the toolbar, click (Review of Systems). Document the review of systems, adding notes as needed.

To add ROS notes at the review of systems level

1. In the *Review of Systems navigation* pane on the left, highlight the *Review of Systems* folder.
2. In the documentation pane on the right, click the note icon to the right of *Review of Systems*.
3. On any of the three tabs, enter information and click **OK** to return to Review of Systems.

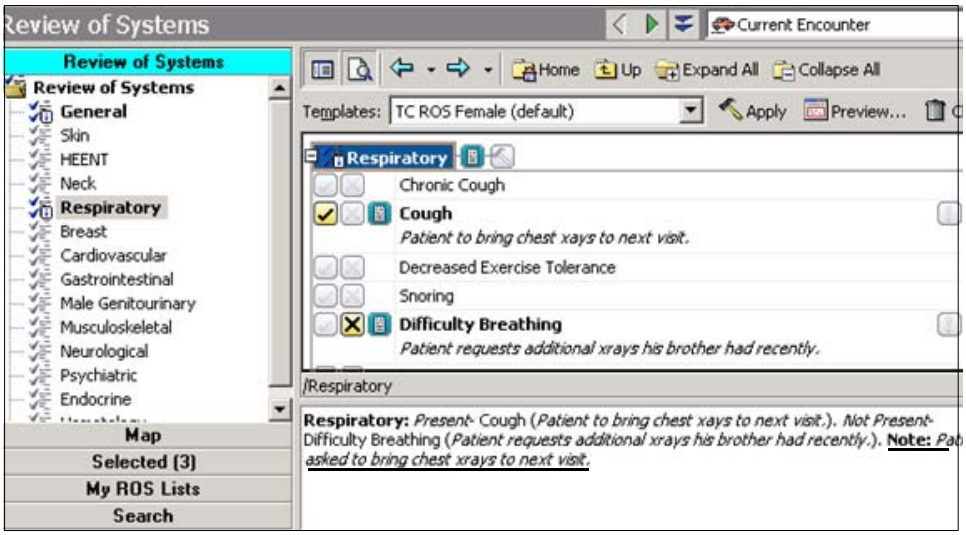


The note icon displays a colored background, and the note text displays at the end of the ROS documentation in the preview pane and on the H&P report.

NOTE: To view the complete text of the note, either click the note icon after *Review of Systems* or view the note in the documentation pane.

To add ROS notes at the system level

1. In the *Review of Systems* navigation pane, select a system, such as *Respiratory.*
2. In the documentation pane on the right, click the note icon to the right of the system.
3. Enter a text note about the selected system, then click **OK** to return to Review of Systems.

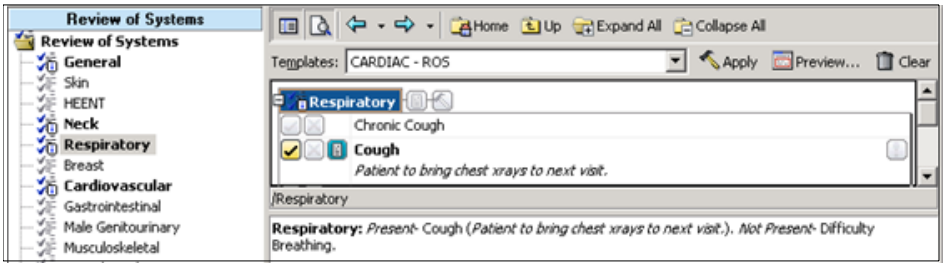


The note icon displays a colored background, and the note text displays after the selected system in the preview pane and the H&P report.

NOTE: To view the complete text of the note, either click the note icon after the system or the note text hyperlink.

To add ROS notes at the detail level

1. In the *Review of Systems* navigation pane, select a system, such as *Respiratory.*
2. In the documentation pane on the right, click a detail, such as Chronic Cough (either positive or negative).
3. Click the note icon, enter a text note about the selected detail, then click **OK** to return to Review of Systems.



The note icon displays a colored background to alert the caregiver that the system includes a note, and the note text displays after the selected detail in the preview pane if selected in caregiver options and the H&P report.

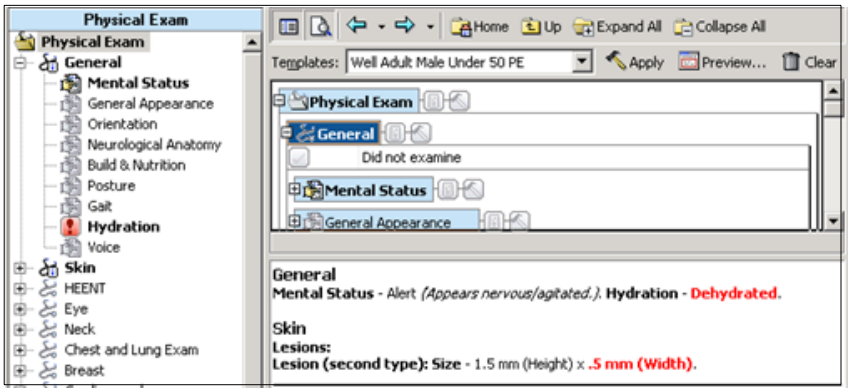
NOTE: To view the complete text of the note, either click the note icon after the system or the note text hyperlink.

Physical Exams

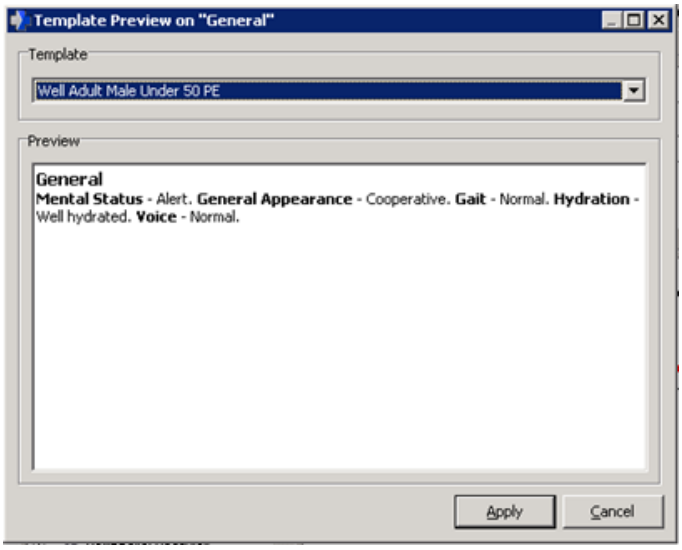
Document Physical Exam (PE) findings by clicking items for each system. You can document PE findings based on templates, previous encounters, or from scratch.

Documenting physical exams using templates

1. With a patient chart open in HealthMatics EMR, from the left pane or the toolbar, click (Physical Exam).



2. Click the **Templates** down-arrow and select one from the list that appears.
3. Click **Preview** (or **Apply** to apply the values to the current encounter without previewing them).


Template Preview on "General"
Template
Well Adult Male Under 50 PE
Preview
General
Mental Status - Alert. General Appearance - Cooperative. Gait - Normal. Hydration - Well hydrated. Voice - Normal.
Apply
Cancel

NOTE: In the Preview pane, you can click the *Template* down-arrow and preview templates until you find the one most appropriate; then click **Apply**.

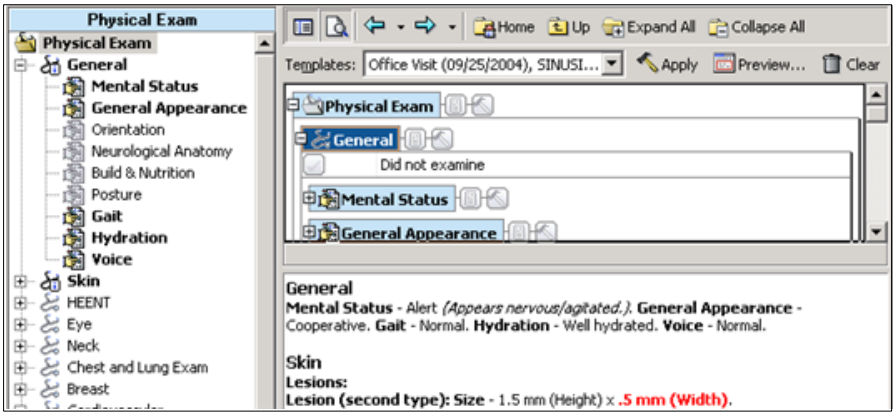
4. Use **one** of the following methods to make changes to the template:

- Click (**+**) as needed, or the hyperlinks in the documentation pane, to edit items examined during the patient visit.
- Make changes by selecting and opening the bolded (documented) systems/ items and making alternative selections as needed in the upper documentation pane to reflect the patient's current condition.
- Click the hyperlink in the current encounter documentation pane to navigate directly to the item you need to edit.

5. To view PE documentation text, highlight *Physical Exam.* PE documentation displays in the lower right pane.

Documenting physical exams using previous encounters

1. With a patient chart open in HealthMatics EMR, from the left pane or the toolbar, click (Physical Exam).



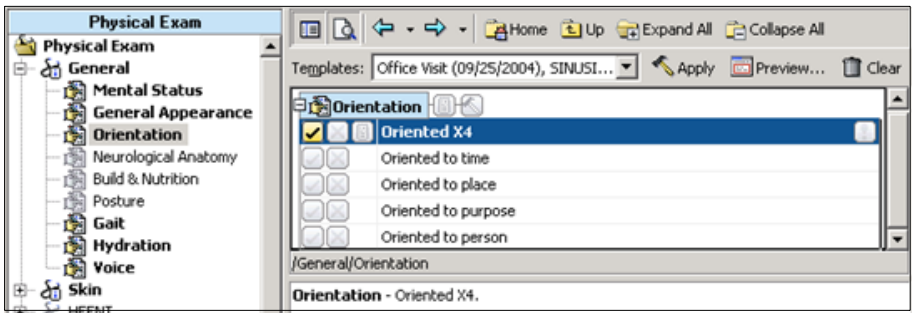
2. Click the **Templates** down-arrow, select the appropriate office visit displayed under the *Encounters section*, then click **Preview** (if you want to view it first) or **Apply**.
3. Use hyperlinks from the current encounter documentation pane (bottom right) to navigate directly to any item you need to edit.
4. Click (**+**) to expand folders and view template documentation as needed to review the systems and values documented.

Documenting physical exams from the beginning

See also Adding review of systems notes on page 282, and Documenting review of systems from the beginning on page 281.

1. With a patient chart open in HealthMatics EMR, from the left pane ***or*** the toolbar, click (Physical Exam).
2. In the *Physical Exam* navigation pane, for each system you want to document, click (**+**) as needed to expand folders and display the characteristics at the level needed for documentation.

3. In the pane on the right, click to document items as needed.



- Physical exam notes can be added at all levels:

  NOTE: Image notes can be added at the physical exam and system level. You can also add an image note in addition to a text note.

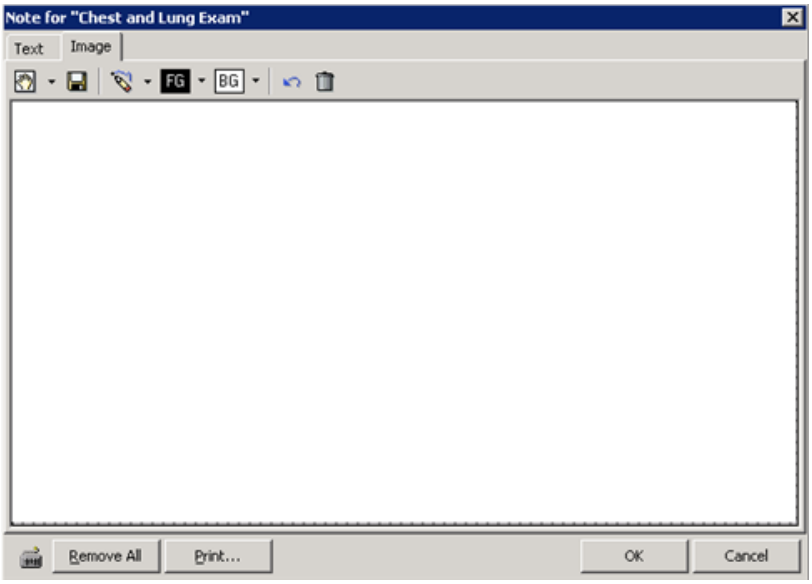
To add physical exam notes

You can add notes at all levels in Physical Exam (from the physical exam encounter level down to the Detail level. The process for adding notes in Physical Exam in the same as in Review of Systems (see Adding review of systems notes on page 282 and Using text in notes on page 344).

To add an image note

At both the Physical exam and System level, you can add an image note in addition to a text note (see Notes on page 344, and Using images in notes on page 345).

1. Click , then the **Image** tab.

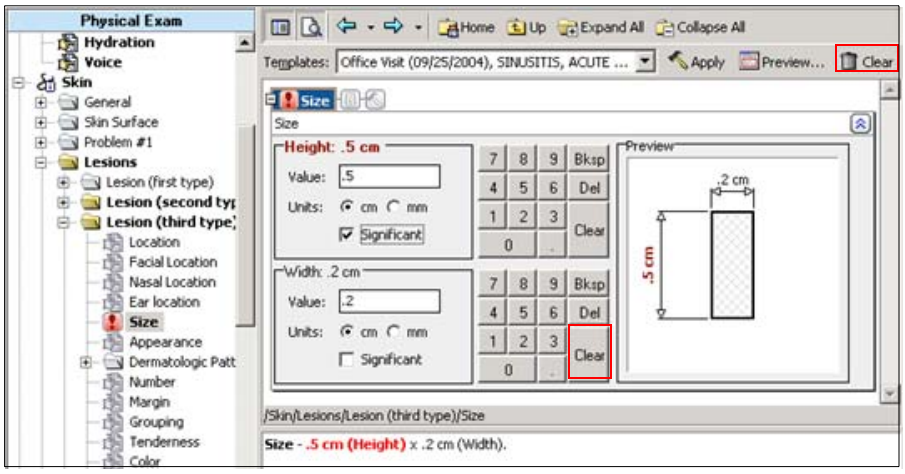


Icon	Action
	Load image - Click down-arrow to select image source: • - File System • - Library • - Import Photo
	Save image to file.
	Pencil drawing tool - Click down-arrow to select from pencil, line, rectangle, filled rectangle, circle, filled circle, or text tools.
FG	Foreground color
BG	Background color
	Undo
	Reload
	Clear

2. Load the image from the image source.
3. Click **OK**.

Documenting measurements and sizes in PE

1. With a patient chart open in HealthMatics EMR, from the left pane ***or*** the toolbar, click (Physical Exam).
2. In the *Physical Exam* navigation pane, click (**+**) as needed to locate a measurement item and click **Size**.



3. In the *Height* and/or *Width* boxes in the measurement pane on the right, do the following:
   - At *Value*, type or use the key pad to enter a value for the height.

     NOTE: To clear the *Value*, click (Clear) on the secondary toolbar, ***or*** click **Clear** on the window keypad.
   - At *Units,* select either **cm** or **mm**.
   - At *Significant*, select the box if the measurement is significant.

     NOTE: If selected, the dimension marked *Significant* (and text in the preview pane) displays in red, and the *Size* icons are replaced with red exclamation points.
   - In the *Preview* box, view the graphic to see a proportional representation of the values selected.

     NOTES
     ***** If a value is entered for only the *Height* or the *Width*, than the *Preview* graphic is linear, rather than two dimensional.

     * The preview graphic is proportional, but is not drawn to scale.
4. In the preview pane at the bottom of the screen, view the documentation generated.

   NOTE: To collapse the *Size* box, click either or in the corner of the upper pane.
5. To include a note about the size, click the note icon (), type a text note, and click **OK**.

The note icon displays with a colored background and the note text displays as an italicized link in the preview pane at the bottom of the screen.

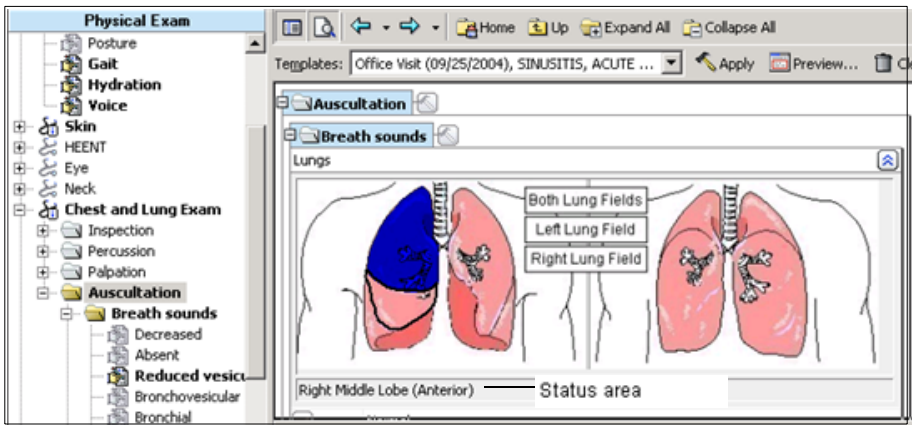
Documenting physical exam using mapped images

1. Open a patient chart, and from the left pane or the toolbar, click (Physical Exam).
2. In the *Physical Exam* navigation pane, select a system (such as Chest and Lung Exam/Auscultation/Breath sounds).
3. Click (**+**) to expand items and locate a mapped image.

NOTES
***** A mapped image exists if the button displays to the right.

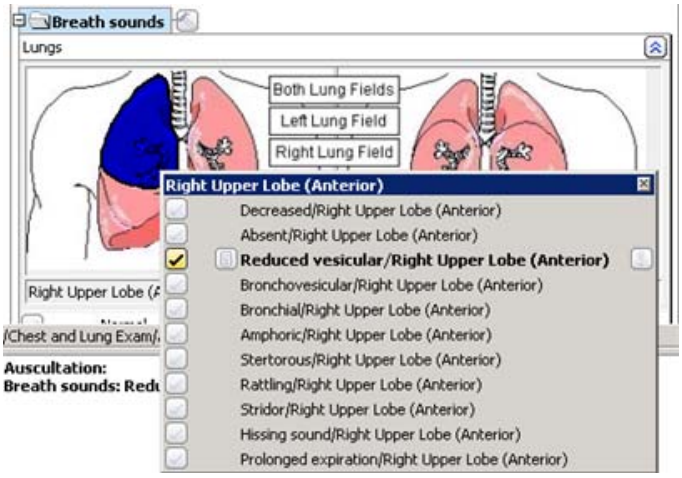
* If you want mapped images to always display expanded, you can select that as a caregiver option.

- Select the item and click the button to open the image.



- Hover over the mapped areas in the image to see the following:
  - > Boundaries of the mapped area are outlined in black.
  - > The name of the area appears in the status area below the image.

4. To display mapped details, click an area on the diagram to display a menu of details mapped to that area.



- Click items to document details for the area selected.
  The following things happen:
  - > On the image, the selected area turns blue.
  - > In the menu box, the item is checked and additional icons display -- on the left for a note, and on the right to indicate the finding was significant.
  - > In the preview pane below, text related to the detail selected appears.
  - > In the *Physical Exam* navigation pane, the detail displays in bold.
- To indicate data for a detail is significant, click the exclamation point icon to the right of the menu item.
  The following things happen:
  - > In the image, the selected area turns red.
  - > The icons to the right of the detail in the drop-down menu and in the *Physical Exam* navigation pane turn red.
  - > In the preview pane, the text describing the affected area turns red.

  NOTE: To delete documentation at the detail level, click the checked item again to deselect it.
- To add a note about the detail, click the note icon ( ) in front of the menu item, enter text and click **OK**.

  NOTE: The note icon is highlighted and the note text displays in italics in the preview pane.
- Close the menu window by clicking on the x in the upper right corner or anywhere outside the menu.

5. Continue documenting other areas and systems as needed.

NOTE: If you document using an image, the text describing the area selected (not the image) displays in the H&P Report.

Assessment/Plan

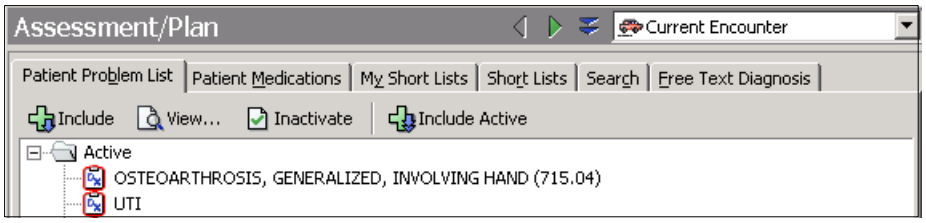
In the Assessment/Plan window, you can do the following:

- Specify diagnoses and treatment.
- Document patient education, discharge plans, office procedures, and nursing services.
- Document referrals and generate referral letters.
- Order medications.

Viewing problem or medication history from A/P

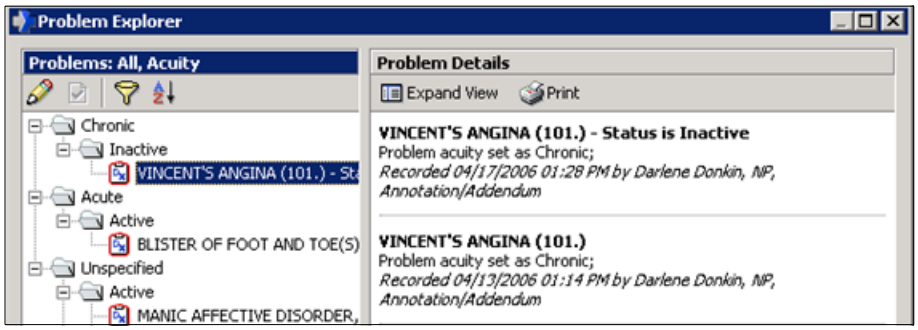
From Assessment/Plan you can view the history of all problems and/or medications for a patient. In addition, you can inactivate both problems and medications from the Assessment/Plan window.

Open a patient chart, and from the left pane or the toolbar, click **A/P** (Assessment/Plan).



To view problem history from A/P

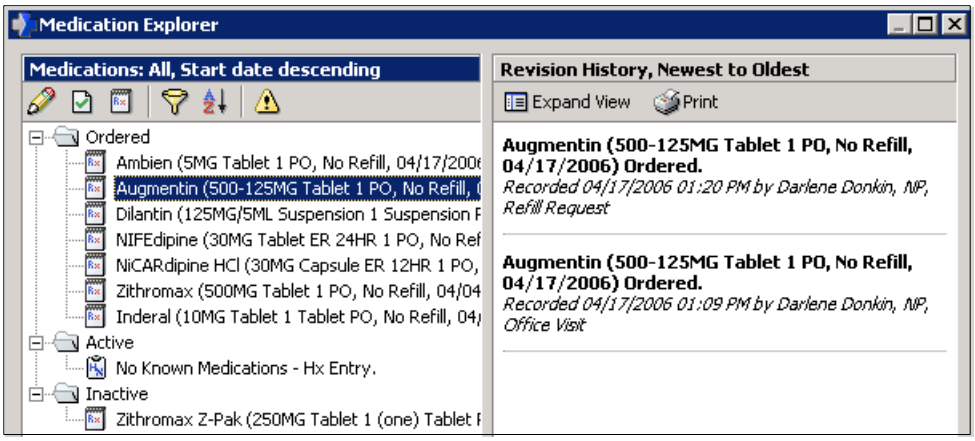
1. In Assessment/Plan, on the **Patient Problem List** tab, click (View).
   - To see a list of all active problems, highlight Active in the left pane.



   - To see a history of a single problem, highlight it in the left pane. The history of the problem displays to the right with the most recent occurrence at the top of the list.
2. To close Problem Explorer, click **X** in the upper right corner.

To view medication history from A/P

1. In Assessment/Plan, click the **Patient Medications** tab.
2. Select a medication and click (View).


Medication Explorer
Medications: All, Start date descending
Ordered
Ambien (5MG Tablet 1 PO, No Refill, 04/17/200
Augmentin (500-125MG Tablet 1 PO, No Refill,
Dilantin (125MG/5ML Suspension 1 Suspension
NIFEdipine (30MG Tablet ER 24HR 1 PO, No Ref
NiCARdipine HCl (30MG Capsule ER 12HR 1 PO,
Zithromax (500MG Tablet 1 PO, No Refill, 04/04
Inderal (10MG Tablet 1 Tablet PO, No Refill, 04/
Active
No Known Medications - Hx Entry.
Inactive
Zithromax Z-Pak (250MG Tablet 1 (one) Tablet
Revision History, Newest to Oldest
Expand View
Print
Augmentin (500-125MG Tablet 1 PO, No Refill, 04/17/2006) Ordered.
Recorded 04/17/2006 01:20 PM by Darlene Donkin, NP, Refill Request
Augmentin (500-125MG Tablet 1 PO, No Refill, 04/17/2006) Ordered.
Recorded 04/17/2006 01:09 PM by Darlene Donkin, NP, Office Visit

- **Medications** - The left pane displays a list of all patient medications.
- **Revision history** - The right pane displays the history of the medication selected in the Medications pane, with the most recent order at the top.
- **Icons** - The icons in Medication Explorer are the same as those on the face sheet (see Face Sheets on page 145).

3. Click the **X** in the upper right corner to close Medication Explorer.

To inactivate problems/medications from assessment/plan

1. In Assessment/Plan, click either the **Patient Problem List** or the **Patient Medications** tab.
2. Right-click an item ***or*** select it and click **Inactivate**.
3. The item moves to the *Inactive* folder.

Specifying assessments and plans

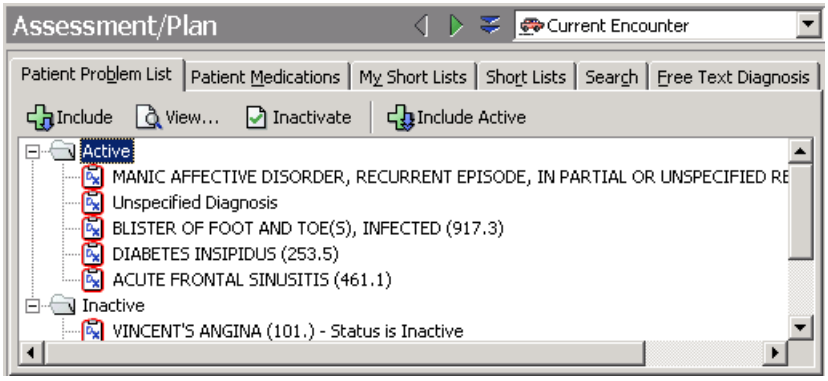
HealthMatics EMR provides several methods for selecting assessments and plans:

- Using patient problem or medications lists for diagnoses or medications recorded previously
- Using short lists (practice and personal favorites)
- Using database libraries
- Entering free-text

To specify assessments and medications using previous lists

In Assessment/Plan, selecting assessments or plans from the *Patient Problem List* tab or the *Patient Medications* tab attaches the current encounter assessment and plan to this previously entered information.

1. Open a patient chart, and from the left pane or the toolbar, click **A/P** (Assessment/ Plan).



2. Click the **Patient Problem List** tab and select a problem and do **one** of the following:

   - Double-click the problem ***or***
   - Select the problem and click **Include** ***or***
   - Right-click and select **Include or**
   - Select the problem and click **Enter** on your keypad ***or***
   - Drag and drop the problem to the bottom pane.

   NOTE: You can also click **Include All** to include all **active** problems in the current encounter.

3. To order a medication ordered previously for the patient, click the **Patient Medications** tab.

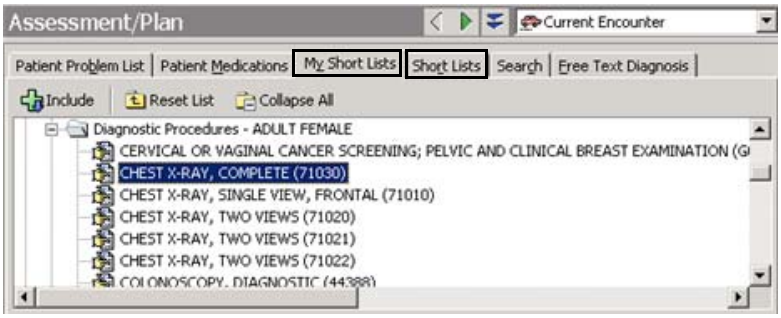
4. With the diagnosis highlighted in the documentation pane, select the medication from the *Patient Medications* list using any of the methods described in step 2.

   NOTES
   * If you link a medication (or other item) to the wrong diagnosis in the documentation pane, click and drag it from the incorrect diagnosis to the correct one.

   * If you search for a medication using *Medi-Span* as the *Data Source*, and you select a medication that was prescribed previously, a message asks if you want to use the existing medication. Click **Yes** (or **Enter**) to attach the medication to the patient's history for that medication. The system displays the most recent order for that medication in the preview pane.

To specify assessments and plans using short lists

1. Open a patient chart and, from the left pane or the toolbar, click **A/P** (Assessment/Plan).
2. Click the **My Short Lists** tab or the **Short Lists** tab.



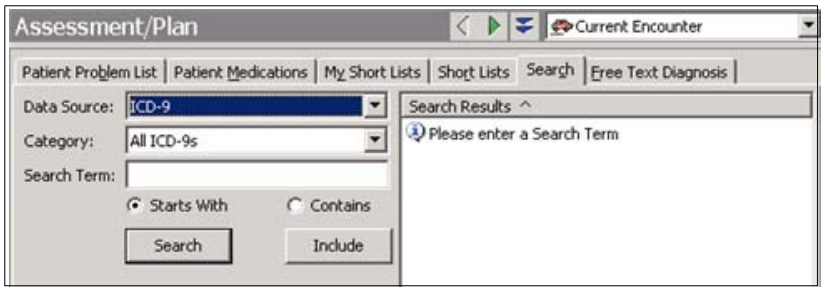
3. Click (**+**) as needed to expand the appropriate short list, and locate assessments/diagnoses.
4. Select a leaf level ( ) item from the short list and add it to the preview pane by doing one of the following:
   - Double-click it ***or***
   - Click and drag it to the preview (lower) pane ***or***
   - Right-click it and select **Include** ***or***
   - Select it and click **Include** on the secondary toolbar.
   - Select it and click **Enter**.

NOTES

- **Reset list** - To collapse the current short list to the first level, click **Reset List**.
- **Collapse all** - To collapse all short lists completely, click **Collapse All**.
- **My short lists** - To add a short list you use frequently to your personal set of short lists, on the **Short Lists** tab, highlight the frequently used short list and click **Add to My Short Lists** ***or*** right-click it and select **Add to My Short Lists**.

To search for assessments and plans using database libraries

1. Open a patient chart, and from the left pane or the toolbar, click **A/P** (Assessment/Plan).
2. Click the **Search** tab.



3. At *Data Source*, click the down-arrow to display source libraries available:

Library	Description
ICD-9	Third-party library that is updated annually
PMS service codes	User-defined codes entered in the Ntierprise Practice Management System that travel across the interface and display in HealthMatics EMR - They can be added to short lists and to the current encounter.
SNOMEDs	Third party library of codes - Items may not function as billable codes and should be used with caution with regard to billing.
CPT (current procedural terminology)	Third-party library of billable codes that is updated annually **NOTE:** Laboratory tests have a separate database (see below).
HCPCS	Level 2 codes that are part of the CPT library
Medications	Third-party library of medications that is updated quarterly
Laboratories	Subset of the CPT library
Referrals	User-defined caregivers to whom the practice refers patients
Patient education	Third-party library called *Clinical Reference System*. Items from this database that are edited and saved to the system are classified as Authored Text (**Tools > Edit Authored Texts**).
Office procedures	User-defined in **Tools > Edit Authored Texts**
Discharge plans	User-defined in **Tools > Edit Authored Texts**
Nursing services	User-defined in **Tools > Edit Authored Texts**
Forms/letters	User-defined in **Tools > Edit Form/Letter Templates**

NOTE: To set the order of these sources, go to **Options > Edit Options > Quick Lists** and, at *Lists*, select **A&P Data Sources** (see To customize quick lists on page 127 for instructions).

4. Select the appropriate *Data Source* to locate the specific assessment, medication, or plan.
5. At *Category*, click the down-arrow to select a subcategory to limit the search if desired.
6. At *Search Term*, enter the ICD-9 or CPT code ***or*** the first few letters of the term and select the appropriate radio button:
   - **Starts with** - To search for entries that begin with the entered letters or numbers. This search is quick, but may be limited.

- **Contains** - To search for all entries that contain the entered letters. This search method is slower, but more inclusive.

7. Click **Search** to begin the search and display results to the right.

   NOTE: If the results of your search includes more than 100 items, only the first 100 display in the *Search Results* pane on the right. At *Search Term*, enter additional characters and click **Search** again, if needed, to limit the results.

8. In *Search Results*, double-click an item or drag and drop it to the documentation (bottom) pane.

   NOTE: If you select a diagnosis or treatment from the *Search* tab that was documented in a previous encounter, the system displays a message indicating that it was previously used.

   * **Yes** (or **Enter**) - The system adds the current encounter information to the history of that problem (or medication).

   * **No -** The system creates a new instance of that problem or medication on the *Patient Problem List* or the *Patient Medications List.*

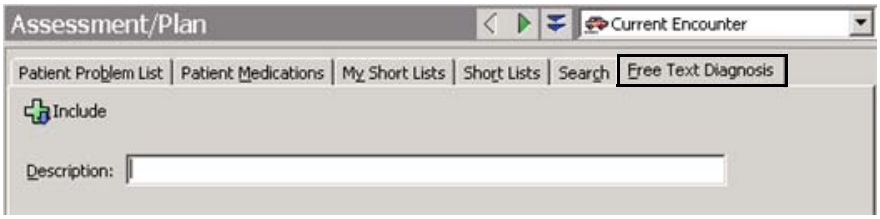
   In most cases, you will click **Yes** to attach the problem to the history to prevent duplicate entries.

To enter free-text diagnoses

You can associate free-text diagnoses with plans. However, plans based on free-text diagnoses do not contain the associated ICD-9 codes and are **not** electronically billable.

1. Open a patient chart, and from the left pane or the toolbar, click **A/P** (Assessment/Plan).

2. Click the **Free Text Diagnosis** tab.



3. At *Description*, enter a free-text diagnosis or treatment that you cannot find on a short list or using *Search* and click **Include**.

4. If you select a diagnosis or treatment from the *Free Text* tab that was documented in a previous encounter, the system displays a message indicating that it was previously used.

   - **Yes** (or **Enter**) - The system adds the current encounter information to the history of that problem (or medication).

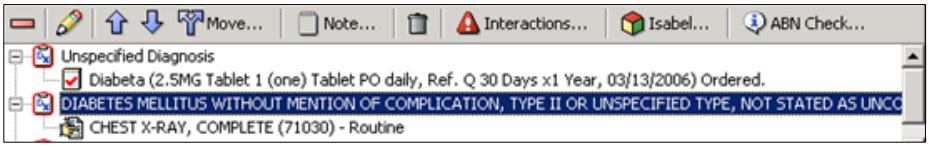
   - **No** - The system creates a new instance of that problem or medication on the *Patient Problem List* or the *Patient Medications List.*

NOTE: In most cases, you will click **Yes** to attach the problem to the history to prevent duplicate entries.

5. Double-click the item in the documentation (bottom) pane to enter additional details and click **OK**.
6. Drag and drop plan items beneath the free-text diagnosis you created in the documentation (bottom) pane.

To indicate primary, secondary, and tertiary diagnoses

1. Open a patient chart, and from the left pane or the toolbar, click **A/P** (Assessment/ Plan).
2. Select multiple diagnoses for the current encounter using any method.
See To specify assessments and plans using short lists on page 294, To search for assessments and plans using database libraries on page 294, To enter free-text diagnoses on page 296.


Move...
Note...
Interactions...
Isabel...
ABN Check...
Unspecified Diagnosis
Diabeta (2.5MG Tablet 1 (one) Tablet PO daily, Ref. Q 30 Days x1 Year, 03/13/2006) Ordered.
DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION, TYPE II OR UNSPECIFIED TYPE, NOT STATED AS UNCO
CHEST X-RAY, COMPLETE (71030) - Routine

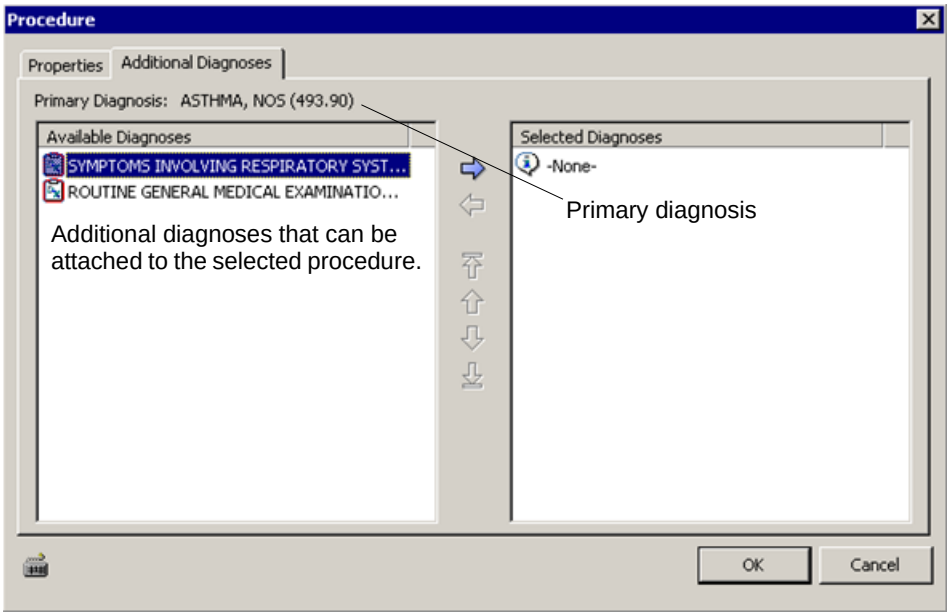
3. Indicate the hierarchy of the diagnoses by clicking icons in the preview (bottom) pane to move them up or down in the list.

Icon	Name	Action
	Delete Item	Delete the selected item.
	Edit Item	Edit the selected item.
	Move Item Up	Move the selected item up one level.
	Move Item Down	Move the selected item down one level.
	Move	Open a dialog box to replace an item.
	Note	Add a note.
	Clear All Items	Clear all items from the preview pane.
	Interactions	Display drug interactions
	Isabel	Access Isabel, a web-based decision support system (purchased module).
	ABN Check	Advance Beneficiary Notice check - includes reason Medicare may not cover a laboratory test.
Billing Level	Billing Level	Select a billing level and add modifiers.

To link multiple diagnoses to a procedure code

In HealthMatics EMR you can send multiple diagnosis codes (ICD-9s) to your practice management system to explain the need for a procedure or lab test. Diagnosis codes available for selection are those already included in Assessment/Plan.

1. With a patient chart open, from the left pane or the toolbar, click **A/P** (Assessment/Plan) and select multiple diagnoses for the current encounter.
2. In the preview (bottom) pane, highlight the primary diagnosis and order a procedure (or lab).
3. To attach multiple diagnoses to it, do any of the following:
   - Double-click the procedure (or lab) ***or***
   - Select it and click ***or***
   - Right-click it and select **Edit**.
4. In the Procedure (or Laboratory) dialog that displays, click the **Additional Diagnoses** tab.

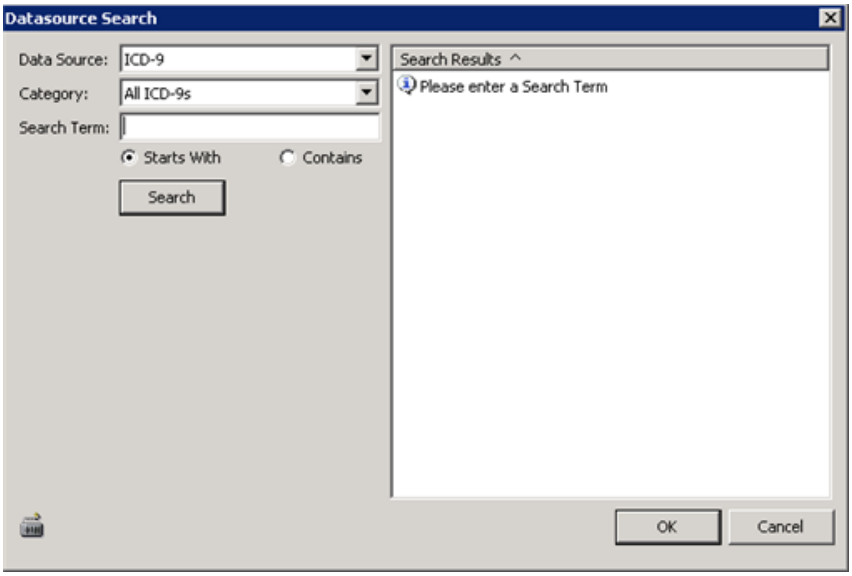


5. In the left pane, attach additional diagnosis codes to the selected procedure or lab test using one of the following methods:
   - Double-click the code ***or***
   - Click and drag it to the *Selected* box ***or***
   - Select it and click .
     The additional code moves to the *Selected* box.
6. Use the up/down arrows to sort the diagnosis codes in the appropriate order with the primary at the top of the list.
7. Click **OK** to return to Assessment/Plan.

To edit diagnoses in A/P

You can update (change) diagnoses and see that change in the Problems list on the patient face sheet.

1. Open a patient chart, and from the left pane or the toolbar, click **A/P** (Assessment/Plan).
2. Select the **Patient Problem List** tab and add the diagnosis you want to upgrade or change to the documentation (bottom) pane.
3. To upgrade and track changes to the diagnosis in the patient problem list, in the documentation (bottom) pane, select it and do one of the following:
   - Double-click ***or***
   - Click (Edit Item) ***or***
   - Right-click it and select **Edit**.
4. In the Problem dialog, click the **Diagnosis** search button ( ) to display Problem Search.



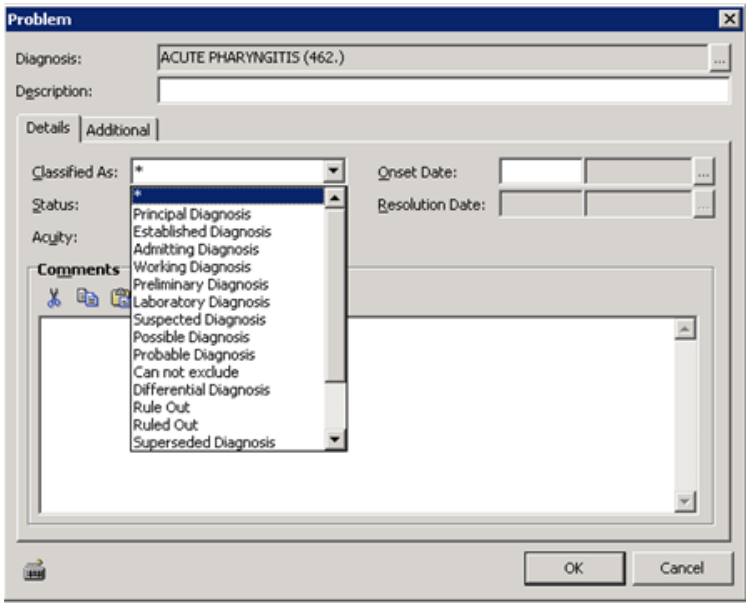
5. Search for the new diagnosis using Data Source, Category, and Search Term (see To search for assessments and plans using database libraries on page 294).
6. In *Search Results*, select the new diagnosis and click **OK**.
7. In the Problem dialog box, fill in other fields, as needed, and click **OK** again. The diagnosis in the Assessment/Plan preview pane reflects the change made.

To classify diagnoses

In Assessment/Plan, you can enter a diagnosis with a specific classification, such as *Admitting, Preliminary, Probable, Definitive Diagnosis Pending*, and many others.

1. Open a patient chart, and from the left pane ***or*** the toolbar, click **A/P** (Assessment/Plan).
2. Select one of the tabs and add a diagnosis to the documentation (bottom) pane.

3. To enter a classification for a diagnosis, in the documentation (bottom) pane, select it and do one of the following:
   - Double-click ***or***
   - Click ***or***
   - Right-click it and select **Edit**.



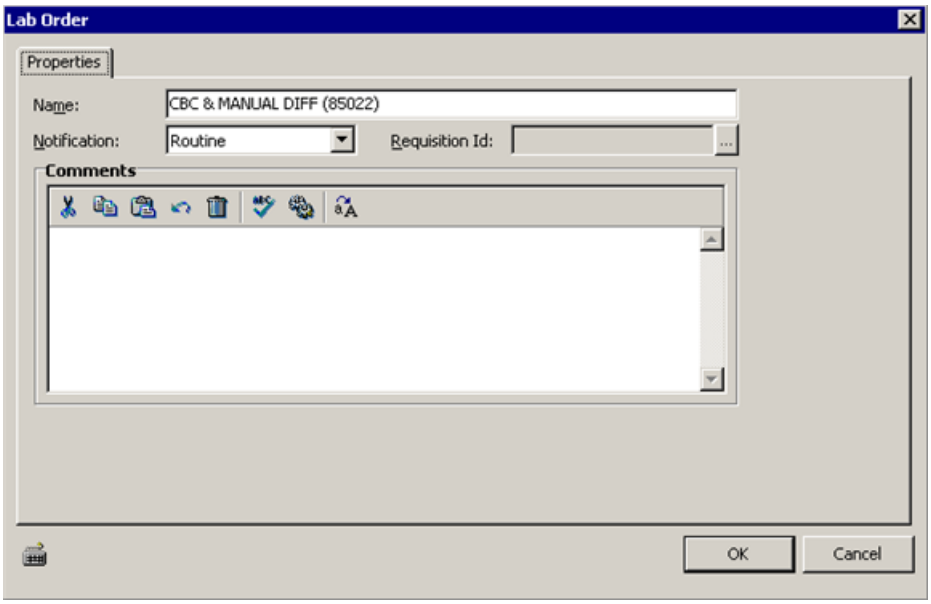
4. At *Classified As*, click the down-arrow and select a classification for the selected diagnosis.
5. Fill in other fields, as needed, to further describe the diagnosis, then click **OK**.

Creating lab requisitions from assessment/plan

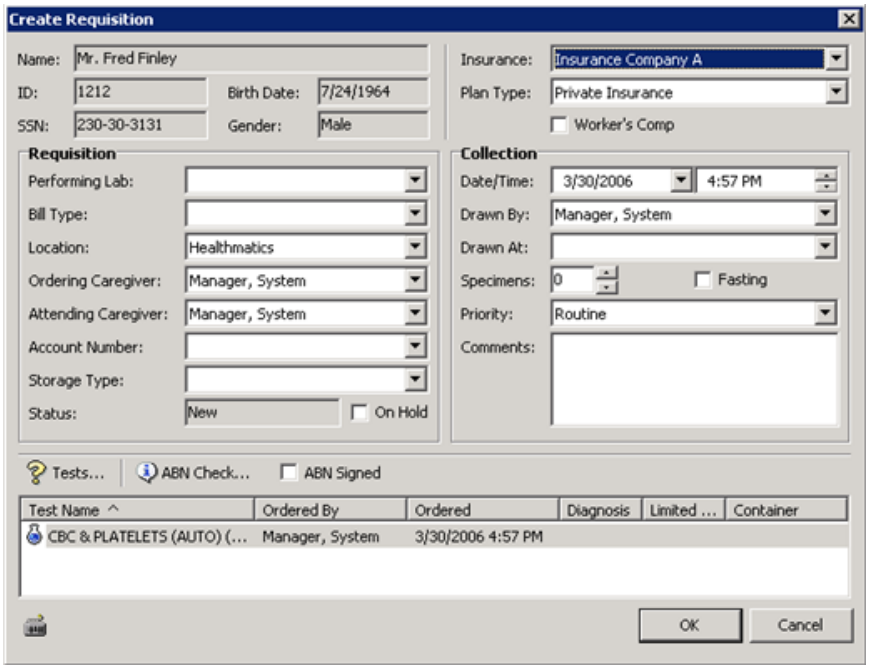
If you collect lab samples, you do not have to go to Lab Order Entry to create requisitions and add collection data. Instead, you can do this dynamically from Assessment/Plan:

1. Open a patient chart, and from the left pane or the toolbar, click **A/P** (Assessment/Plan).
2. Click either **Short Lists** tab or the **Search** tab and order a lab test.
3. In the preview (lower) pane, select the test and do one of the following:
   - Double-click it ***or***
   - Click ***or***
   - Highlight it and press **F2** ***or***

- Right-click it and select **Edit**.



4. Click the **Requisition id** search button ( ).



NOTE: This is the same dialog that displays from **Office > Orders** where you select a patient lab order, double-click it, and **Create Requisition** displays.

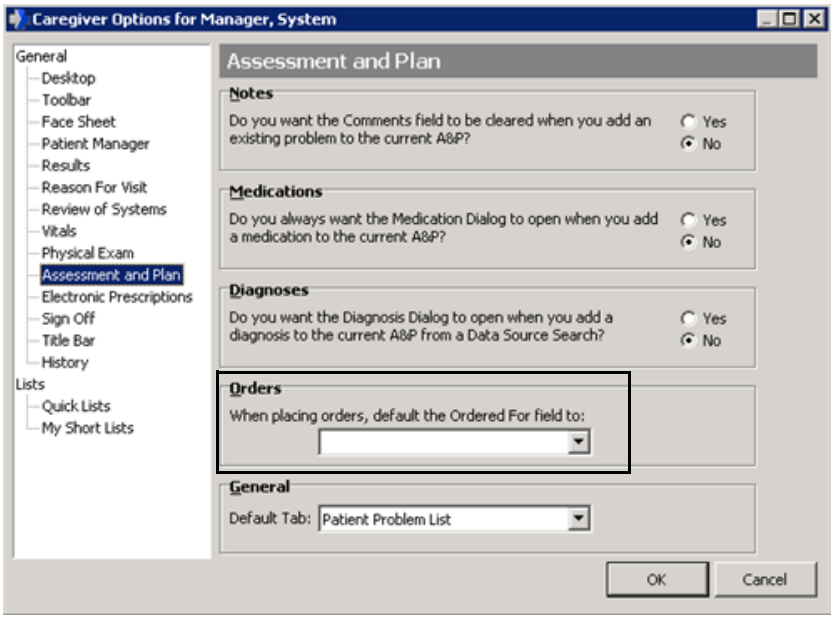
Ordering on behalf of another caregiver

You can order labs and procedures on behalf of another caregiver in A/P. The primary benefit of this option is that when lab orders print at Signoff or from the Output Queue, the labs will display as ordered on behalf of the *Ordered For Caregiver*, if one was specified in Caregiver Options.

To set order on behalf of caregiver option for A/P

Based on the caregiver option, when a lab or procedure is ordered in A/P, the *Ordered For* field on the edit Lab Order or Procedure dialog defaults to the appropriate caregiver. If *Preferred* or *Appointment Caregiver* is the caregiver option, the caregiver that represents the caregiver must be one of the caregiver's grantors for the *Ordered For* field to default properly.

1. From HealthMatics EMR menu, click **Options > Edit Options > General > Assessment and Plan > Orders**



2. Click the **Orders** down-arrow to select the caregiver for the *Ordered for* field default to.
   HINT: Choices include *Appointment Caregiver, Preferred Caregiver, Blank* (the default for none), and a list of grantors to select from.

3. Click **OK**.

Ordering and viewing medications from assessment/plan

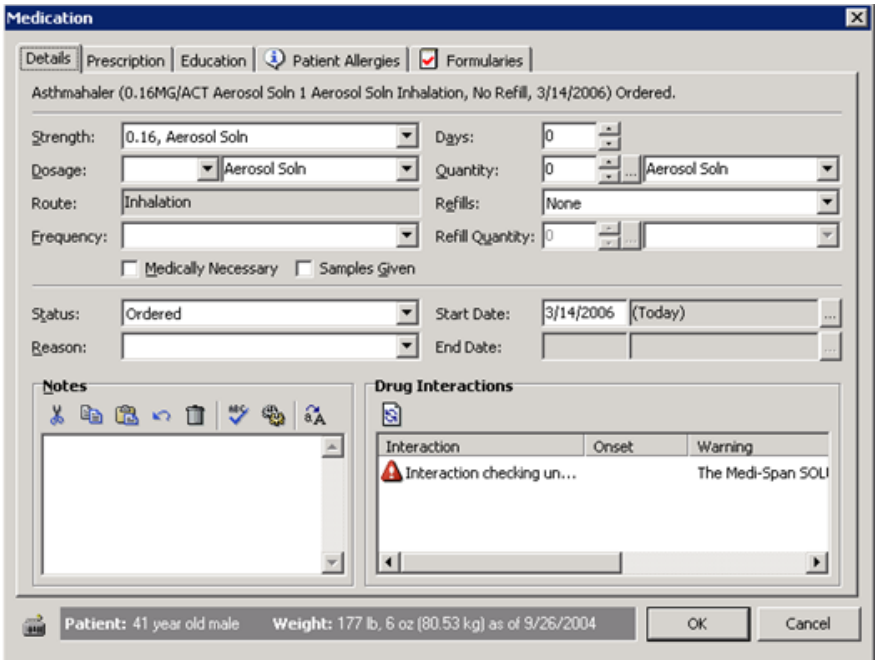
From Assessment/Plan, you can order new medications, view potential medication interactions, and print, fax, or electronically transmit prescriptions.

To order new medications

You can order new medications as part of a treatment plan. (Notice that refill requests are different from new medication orders.)

1. Open a patient chart, and from the toolbar, click **A/P** (Assessment/Plan).
2. Select a diagnosis for the current encounter from any of the five tabs (see Specifying assessments and plans on page 292).
3. To order a medication, in the preview (lower) pane, highlight the diagnosis then search for the medication you want to order from any of the four tabs described in Specifying assessments and plans on page 292.
4. In *Search Results*, double-click or drag-and-drop the medication to the current encounter to order it. The Medication dialog appears.

   NOTE: If you select a medication from *Patient Medications* or a short list and the Medication dialog doesn't open automatically, double-click the medication ***or*** click ***or*** press **F2** ***or*** right-click the medication and select **Edit** from the pop-up menu to enter prescribing information.



NOTES

* If a patient has allergies reported, a *Patient Allergies* tab displays at the top of the screen. Click it to see allergy information. If the patient does not have allergies recorded, this tab does not appear.

* Patient age and the most recently recorded weight (along with the date the

weight was measured) display prominently at the bottom of the screen. If the patient does not have a weight on record, the weight field displays *(not available)*.

5. On the *Details* tab, enter information in the following fields.

   - **Strength -** Click the down-arrow to select a different strength from available strengths.
   - **Dosage** - Clicking the down-arrows, in the first field, select (or enter) the dosage, and in the second field, select the form.
   - **Route** - Medi-Span fills in this field.
   - **Frequency** - Type or click the down-arrow to enter how often the medication should be taken.
   - **Medically necessary** - Select to indicate medication is medically necessary and should be dispensed as written without substitutions. “Medically Necessary” prints on the prescription.
   - **Samples given** - Select to indicate the patient received medication samples. When checked, *Samples given* displays in the Assessment/Plan and the H&P report.

     NOTE: You might want to include a *Note* with the number of samples dispensed.
   - **Days** - Type a number or click the spin arrows to display the number of days the patient should take the medication.
   - **Quantity** - Type the quantity in the field, click the spin arrows to indicate the number, or click the ellipsis ... button to display the prescription quantity writer’s table.

     Use the rows of numbers on the table as follows:

     > Use the first row to select the most common quantities.

     > Use the second row to select the most common monthly quantities.

     > Use the third and fourth rows to add additional quantities to the numbers in the first or second rows.

     > Use the QS key to indicate the prescription should be filled with “quantity sufficient” based on the amount to be taken per day, times the number of days prescribed.

     > Enter the quantity to be dispensed and click **OK**.
   - **Quantity** (drop-down list) - Type or click the down-arrow to enter the form or type of units. **Example:** tabs, caps, drops, and so forth.
   - **Refills** - Click the down-arrow to select the number of refills.

- **Refill quantity** - If refills were specified in the field above, click the spin arrows or ellipsis button to indicate the number of refills authorized.

  NOTE: Once you document the number of days and the refills are set at 0, a *Do Not Auto Inactivate* checkbox displays. Check the box if you do not want this medication to automatically inactivate when the course is complete. If you change refills to a frequency other than 0, the *Do Not Auto Inactivate* checkbox disappears.

- **Status** - Click the down-arrow to select a status for the prescription.

Status	Medication Description
Ordered	Ordered medication (default)
Continued	Reactivated medication either discontinued or inactivated.
Discontinued	Inactive medication
Active	Active medication
Inactive	Completed course of medication
Erroneous Entry	Medication entry was in error. **NOTE:** The medication displays in Assessment/Plan and Problem History, but not on the patient face sheet.

NOTES
* When the status *Discontinued* or *Inactive* is selected, an *End Date* field displays and defaults to current date, and the *Prescription* and *Education* tabs disappear.

* Only active, continued, and ordered medications are checked for interactions when a new prescription is written. Therefore, it is recommended caregivers consider all medications active until they change the status of the medication.

* Medications added as authored text are not checked for interactions.

- **Reason** - If you changed the *Status*, click the *Reason* down-arrow to select the reason for the change.
- **Start date** - If the prescription status is *Active, Ordered* or *Continued*, enter a date (for instructions, see Entering dates on page 10).
- **End date** - If the prescription status is changed to *Discontinued* or *Inactive*, enter the date the prescription ends.
- **Drug interactions** - To view interaction information, double-click the medication in the *Interaction* box or select it and click (Preview). Drug/drug, drug/food, or drug/allergy interactions display in the Drug Interaction Report:

  NOTE: The latency period is built into the check for medication interactions and is calculated from the prescription end date.

To view medication interactions

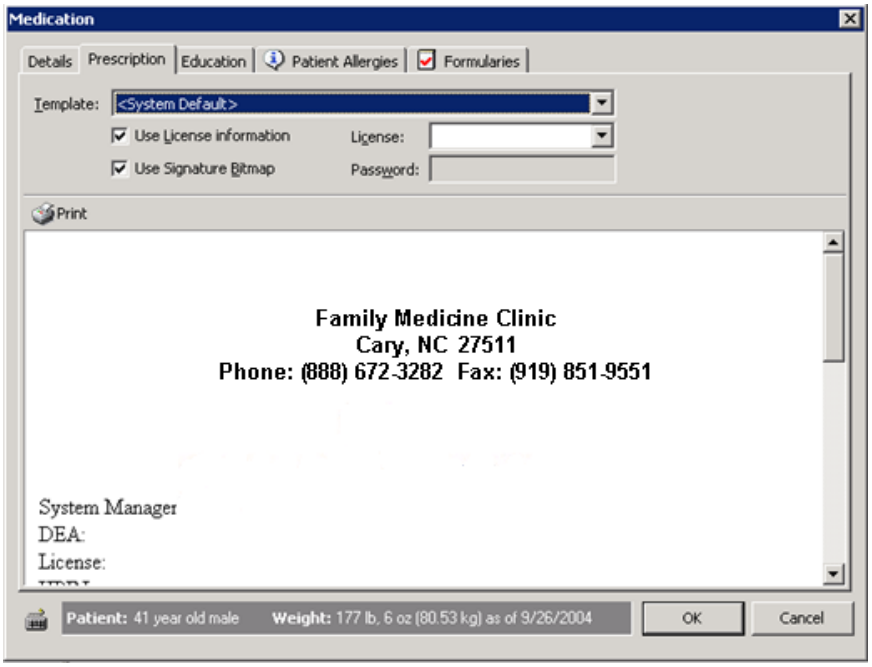
An **Interactions** button displays on both the Face Sheet ( ) and the Assessment/Plan ( ) views. The icon color represents the following interaction severity.

- **Red** – Major interactions
- **Yellow** – Moderate interactions
- **White** – Mild interactions

Click the interaction button to see expanded information about the interactions and the severity. These are provided by the Medi-Span database.

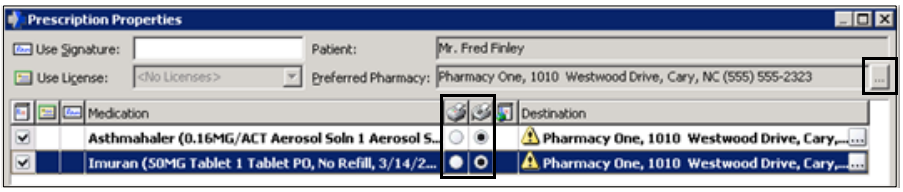
To print, fax, or electronically transmit prescriptions

1. With a patient chart open in HealthMatics EMR, from the left pane or the toolbar, click **A/P** (Assessment/Plan).
2. Order a medication for the current encounter (see Specifying assessments and plans on page 292).
3. In the preview (lower) pane, double-click the medication ***or*** select it and click .
4. Click the **Prescription** tab.



5. At *Template*, click the down-arrow and select the appropriate template for the prescription.
6. If you are using an electronic signature, enter your *Password*.
7. Click **Print** then click **OK** in the Print box that displays.

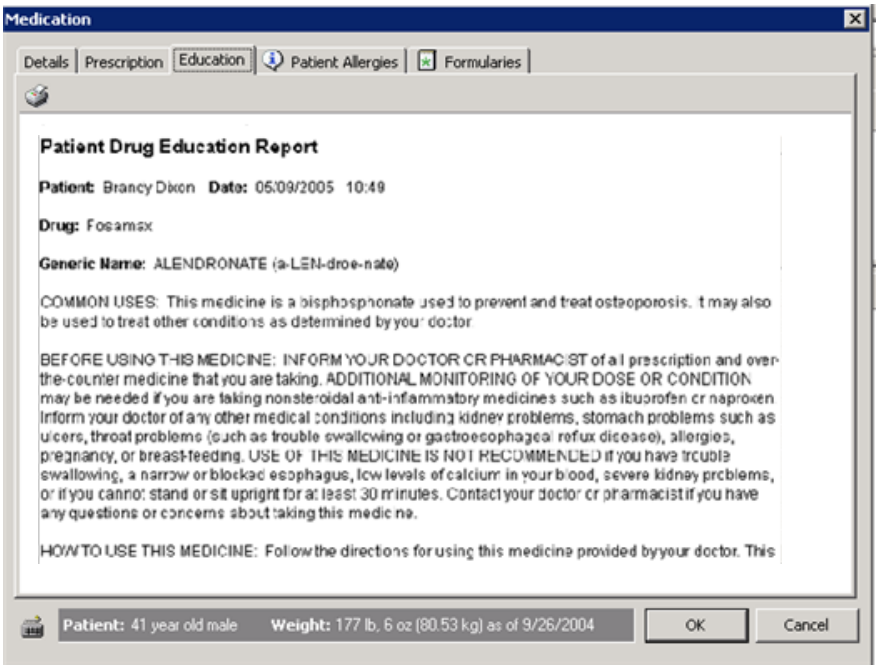
NOTE: You can also print prescriptions when you sign off from an encounter on the H&P window. To do so, click the *A&P Prescriptions* checkbox and then click **OK**.



- If the *Preferred Pharmacy* displayed is not the correct one, click ... to search for the correct one using the Pharmacy Search dialog box.
- Then do **one** of the following:
  - > **Fax** - To fax the prescription, click the medication radio button beneath the Fax icon and click **OK**.
  - > **Electronically transmit** - To electronically transmit the prescription (available only to pharmacies that have EDI IDs), click the medication radio button beneath the Electronic Prescribe icon and click **OK**.
  - > **Print** - To print the prescription, click the medication radio button beneath the print icon and click **OK**.

To print medication patient education information

1. Open a patient chart, and from the left pane or the toolbar, click **A/P** (Assessment/Plan).
2. In the preview (lower) pane, double-click an ordered medication or select it, then click .
3. Click the *Education* tab to display the *Patient Drug Education Report.*


Medication
Details
Prescription
Education
Patient Allergies
Formularies
Patient Drug Education Report
Patient: Brancy Dixon Date: 05/09/2005 10:49
Drug: Fosamax
Generic Name: ALENDRONATE (a-LEN-droe-nate)
COMMON USES: This medicine is a bisphosphonate used to prevent and treat osteoporosis. It may also be used to treat other conditions as determined by your doctor.
BEFORE USING THIS MEDICINE: INFORM YOUR DOCTOR OR PHARMACIST of all prescription and over-the-counter medicine that you are taking. ADDITIONAL MONITORING OF YOUR DOSE OR CONDITION may be needed if you are taking nonsteroidal anti-inflammatory medicines such as ibuprofen or naproxen. Inform your doctor of any other medical conditions including kidney problems, stomach problems such as ulcers, throat problems (such as trouble swallowing or gastroesophageal reflux disease), allergies, pregnancy, or breastfeeding. USE OF THIS MEDICINE IS NOT RECOMMENDED if you have trouble swallowing, a narrow or blocked esophagus, low levels of calcium in your blood, severe kidney problems, or if you cannot stand or sit upright for at least 30 minutes. Contact your doctor or pharmacist if you have any questions or concerns about taking this medicine.
HOW TO USE THIS MEDICINE: Follow the directions for using this medicine provided by your doctor. This
Patient: 41 year old male
Weight: 177 lb, 6 oz (80.53 kg) as of 9/26/2004
OK
Cancel

4. To print the information, click .

   NOTE: If Spanish was the language selected in Demographics for this patient, patient education displays and prints in Spanish.

5. Click **OK** to close.

To use formularies

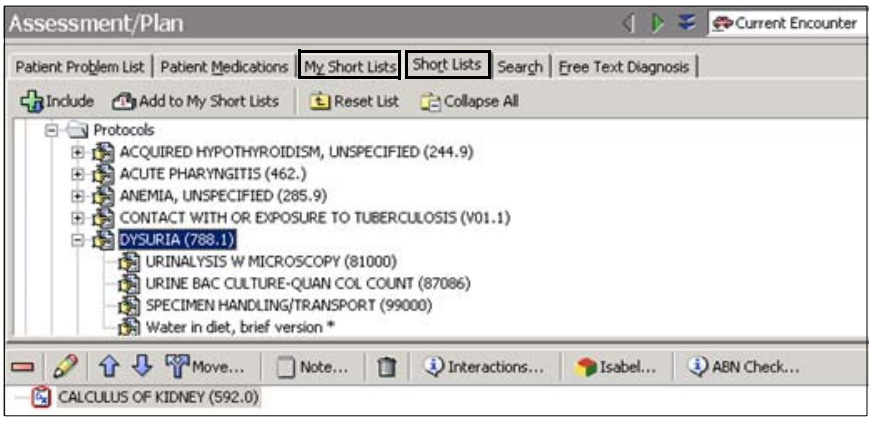
1. Open a patient chart, and from the left pane or the toolbar, click **A/P** (Assessment/Plan).
2. In the preview (lower) pane, double-click an ordered medication or select it, then click .
3. Click the *Formularies* tab.
4. View information related to how the patient formulary classifies the medication and the estimated cost if available.
5. Click **OK** to save Medication Properties and exit.

Using protocols

Protocols are groups of orders associated with one ICD-9 code (the equivalent of standard treatment plans). By selecting a protocol, the diagnosis and all the standard orders become part of the current encounter.

NOTE: For **p**rotocol details see the HealthMatics EMR ***Clinical Customization*** manual.

1. Open a patient chart, and from the left pane or the toolbar, click **A/P** (Assessment/Plan).
2. Click one of the **Short List** tabs that contains a customized protocol.



3. Click (**+**) signs as needed to locate and select a protocol from the upper pane, then do one of the following:
   - Drag it to the lower pane ***or***
   - Select the protocol and click **Include** ***or***
   - Right-click the protocol and select **Include**.

NOTES

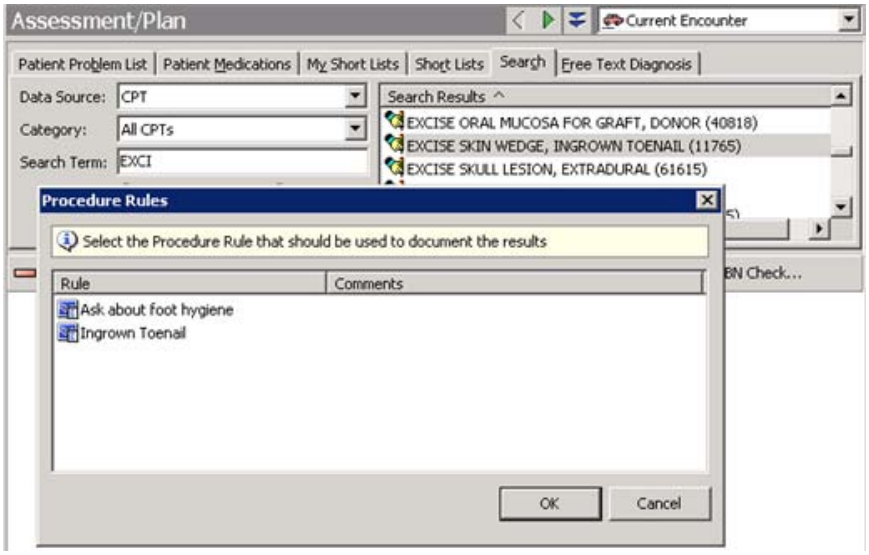
- To remove any unwanted orders, select the order in the preview (bottom) pane and click (Delete Item) ***or*** right-click the order and select **Delete**.
- You can also add additional orders to the treatment plan.

Using procedure entry rules

In the Clinical Customization Module, create procedure entry rules to assist with the documentation process. For instructions, refer to the HealthMatics EMR ***Clinical Customization*** manual.

To order procedures with rules attached

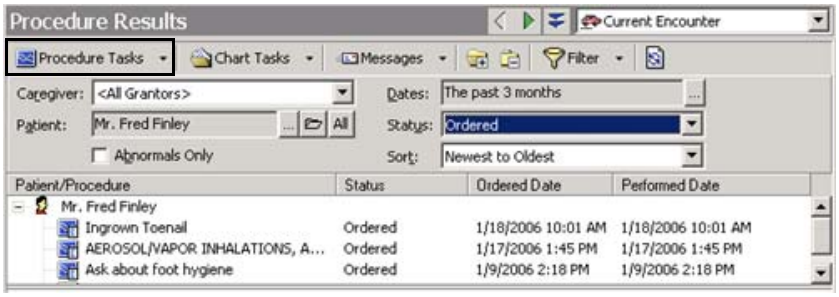
1. With a patient chart open in the HealthMatics Clinical Module, from the left pane ***or*** the toolbar, click **A/P** (Assessment/Plan).
2. Select an assessment and search for a procedure with a rule attached (see Specifying assessments and plans on page 292).



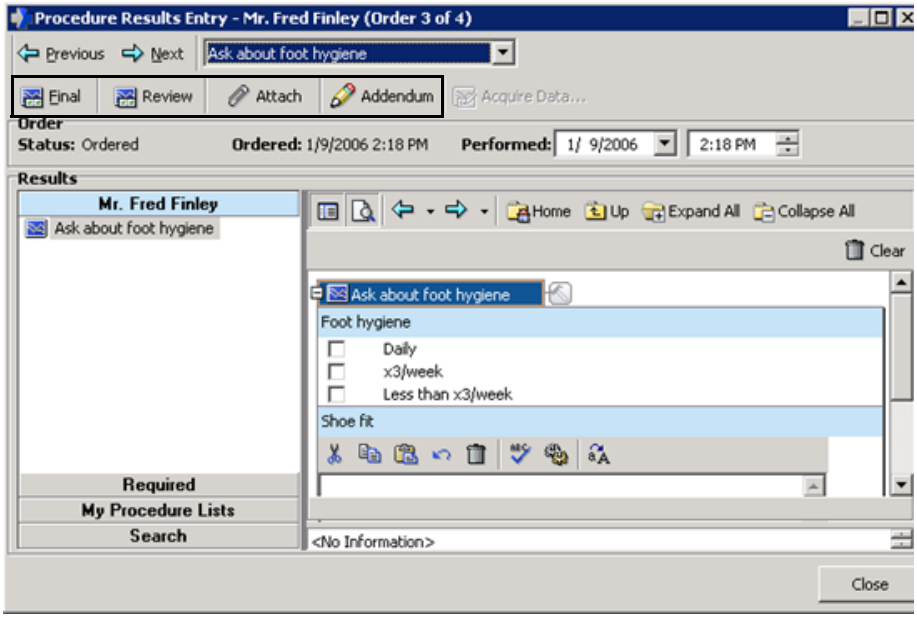
NOTE: If the CPT code you select has more than one rule attached to it, select the correct rule for the patient from the Procedure Rules dialog box, then click **OK**.

To enter results of procedures with rules attached

1. With the patient chart open, from the left pane ***or*** the toolbar, click (Procedure Results).



2. Click the **Status** down-arrow and select **Ordered**.
3. To open the procedure rule, select the procedure and do one of the following:
   - Double-click it ***or***
   - From the Procedure Results toolbar, click **Procedure Tasks > Result Entry** ***or***
   - Right-click it and select **Procedure Tasks > Result Entry**.



NOTES

* The Procedure Results Entry dialog box has three panes similar to the Review of Systems and Physical Exam views. For detailed instructions for using the navigation pane on the left, see ROS and PE Navigation on page 266.

* The *Required* tab lists questions in the Procedure Entry Rule that are required prior to finalizing the rule. *My Procedure Lists* uses this functionality to focus in on questions within a rule that you are responsible for, that is, rules that both nurse and physician input data.

4. Click and enter each value as needed to document result

Icon	Action
Final	Finalize procedure results.
Review	Review procedure results.
Attach	Attach results to: • Original encounter • Current encounter • Both encounters • Cancel
Addendum	Add note if desired.

Use the note and significant icons as needed in your documentation. When documentation is complete, click **Final, Review**, **Attach** or **Addendum** as needed.

NOTE: Following your action choice, a notification message displays that the selected action was taken.

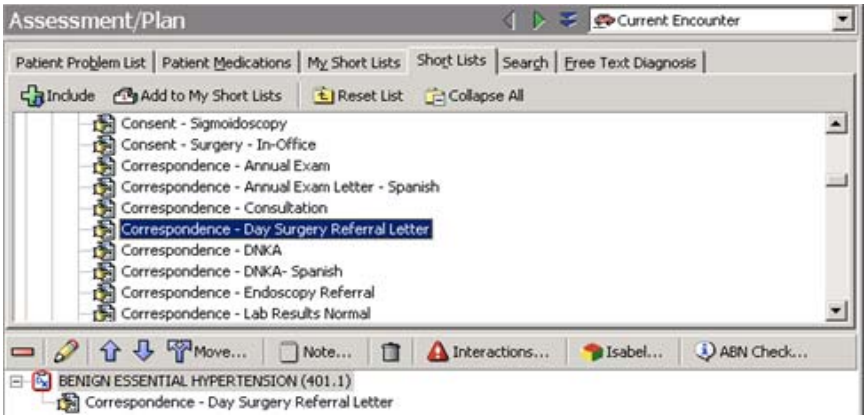
Documenting referrals

To document a referral, select a letter from a short list and then print, fax, or email the letter.

Option 1 - Select referral letters

Referral letter templates determine what encounter information displays in the referral letter. For instructions for creating referral letter templates, see the HealthMatics EMR ***Clinical Customization*** manual.

1. Open a patient chart, and from the left pane ***or*** the toolbar, click **A/P** (Assessment/ Plan).
2. Click one of the **Short Lists** tabs and click (**+**) to open a Forms & Letters folder under a diagnosis ***or*** the *Master - Forms and Letters* ***or*** use the **Search** tab.



NOTE: Create a forms and letters short list folder in the Clinical Customization

Module. For instructions, see the HealthMatics EMR ***Clinical Customization*** manual.

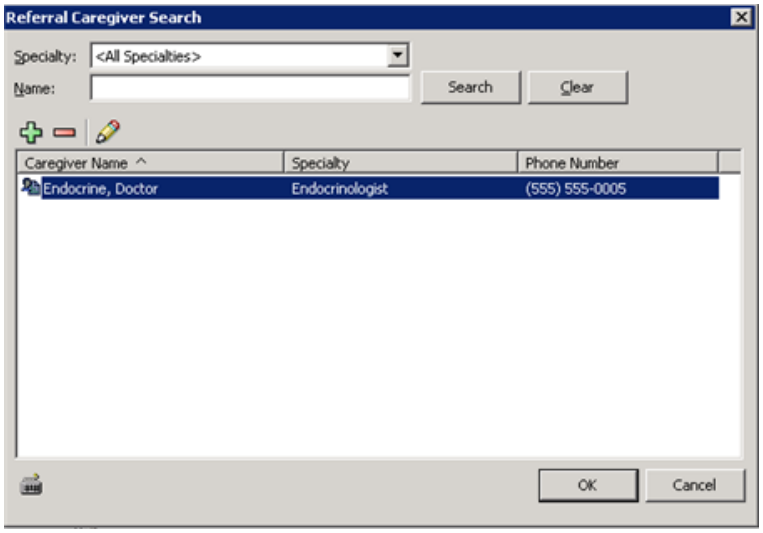
3. To select a referral/consultation letter, double-click it ***or*** drag it to the preview (bottom) pane ***or*** select it and click **Include**.

   - **IF** a referring caregiver was entered in patient Demographics , a confirmation message displays.

     > Click **Yes** to send the letter to the patient's referring caregiver on record.

     > Click **No** to display Referral Caregiver Search, which allows you to select a different caregiver as the recipient.

   - **IF** no referring caregiver was entered for the patient in Demographics, Referral Caregiver Search displays.



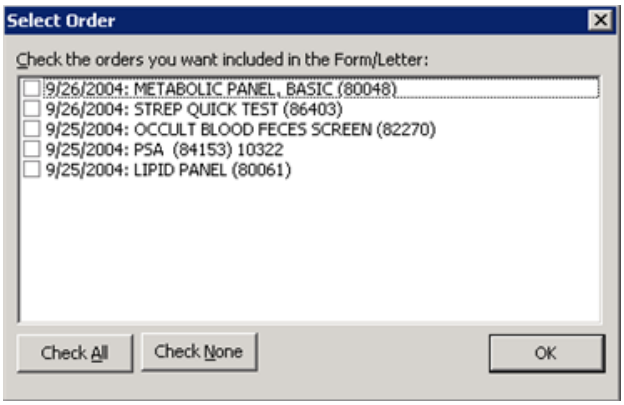
     > At *Specialty*, click down-arrow to select the referral caregiver specialty if desired.

     > At *Name*, enter a few characters of the caregiver name and click **Search**.

     > From the list that displays, select the appropriate caregiver and click **OK** to place that caregiver name in the letter.

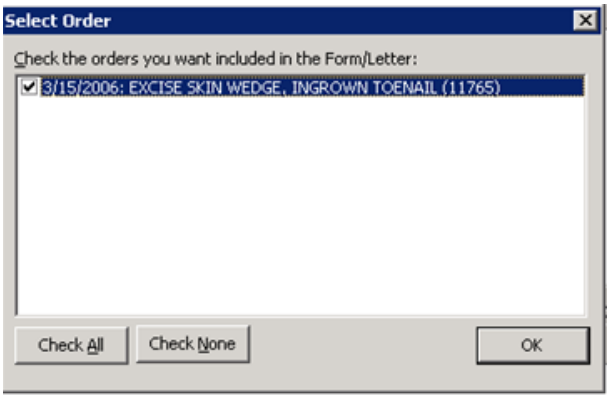
     NOTE: If the caregiver is not in the database, click **Add** and add the caregiver.

- Depending on the form you select (Referral-Referral for example), if labs were ordered, Select Order appears.


Select Order
Check the orders you want included in the Form/Letter:
9/26/2004: METABOLIC PANEL, BASIC (80048)
9/26/2004: STREP QUICK TEST (86403)
9/25/2004: OCCULT BLOOD FECES SCREEN (82270)
9/25/2004: PSA (84153) 10322
9/25/2004: LIPID PANEL (80061)
Check All
Check None
OK

  Select the orders you want to include in the letter, then click **OK**.

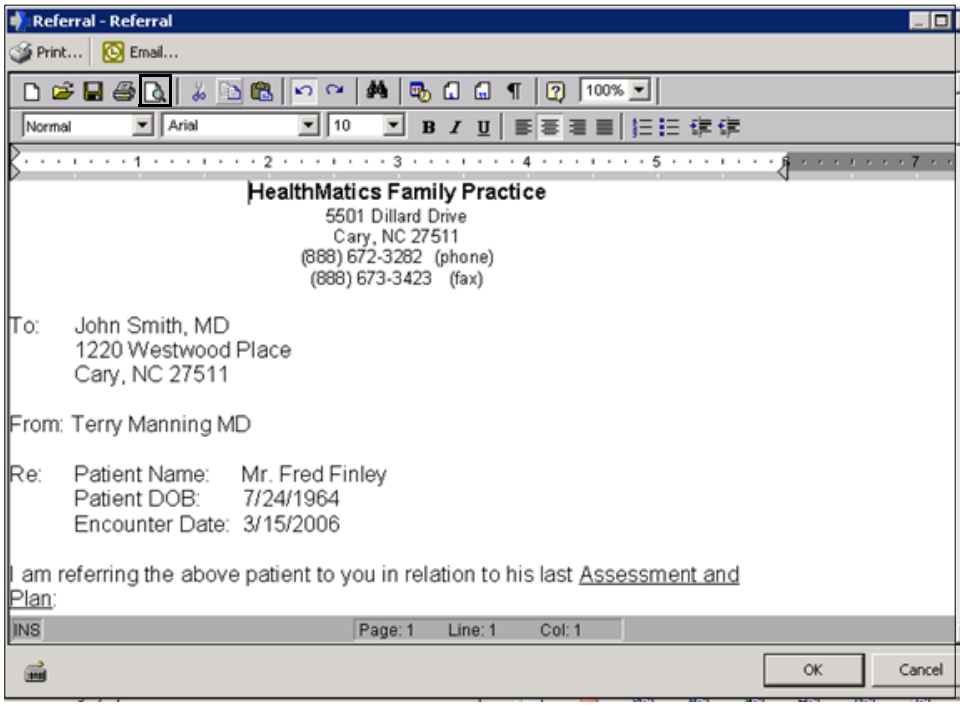
- If procedures were ordered, Select Order appears.



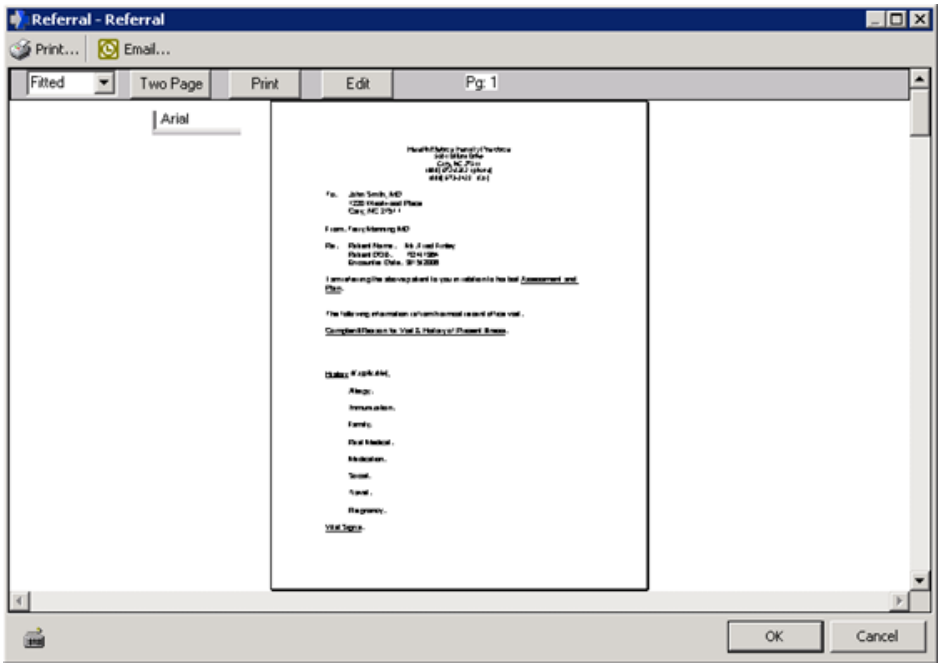
  Select any procedure orders you want to include in the letter.

- If no procedures are ordered, a warning message states, *There are no Procedure orders for this patient*.

4. To view the letter, double-click it in the current encounter (bottom) pane.



5. If needed, edit the letter in the editor pane.
(Optional) Click Print Preview to view finished letter.



6. After editing the letter (if necessary), print or email it:

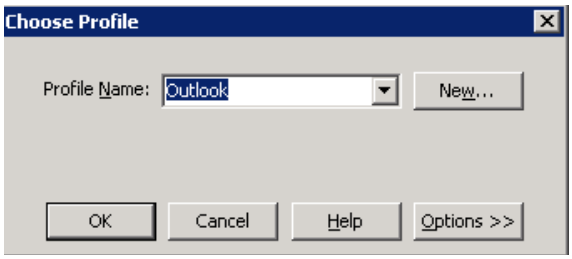
- **Print** - To print the letter, click **Print**.

  > Select the printer and print properties.

> Click **OK** again to close Review window.

- **Email** - To email the letter via Microsoft Outlook Email (**IF** MS Outlook is set up for emailing from HealthMatics EMR), click **Email**.

  > Select a *Profile Name* and click **OK**.
  An email is created with the subject line appropriately completed and the letter attached.



  > Click **OK** to close the Review window.

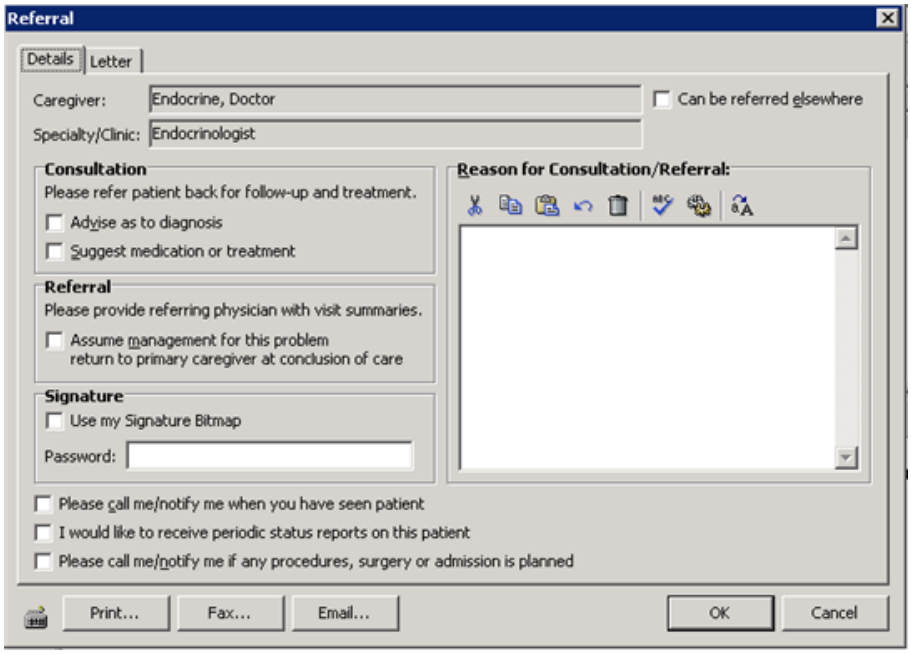
  NOTE: Ensure appropriate encryption prior to emailing patient information.

Option 2 - Make referrals using letters associated with caregivers

You can pre-enter frequently used referral caregivers and caregiver-associated properties into a short list to generate a referral letter. (For details about creating referring caregiver short lists, see the HealthMatics EMR ***Clinical Customization*** manual.)

1. Open a patient chart, and from the left pane ***or*** the toolbar, click **A/P** (Assessment/Plan).
2. Click the **Search** tab and search for the referral caregiver.
   - At *Data Source*, select **Referrals**.
   - At *Category*, select a category to narrow the search, if desired.
   - At *Search Term*, enter the first few letters of the caregiver last name if desired and click **Search**.

3. Double-click the caregiver name to send the referral to, ***or*** drag and drop, ***or*** select and click **Include** to display Referral.



NOTES

***** Under *Signature*, if you select the *Use my Signature Bitmap* box and enter your *Password* (if required), the electronic signature you have on file in the database appends to the referral letter when you click **OK, Print**, **Fax** or **Email**.

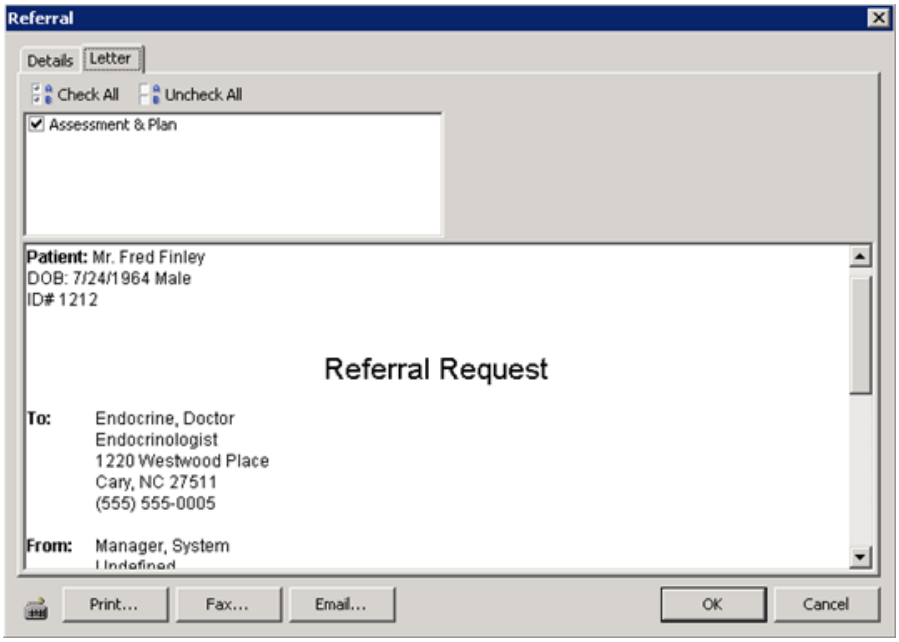
* If *Use my Signature Bitmap* is checked, when screen date saves to the database, the *Details* tab in the Referral dialog box is **only** accessible to the caregiver who effectively "signed" the letter. Other caregivers can view the *Letter* tab, but not the *Details* tab.

4. Complete referral dialog screen.

Screen Element	Action
Caregiver and Specialty/Clinic	These fields default from Data Search selections.
Can be referred elsewhere	Check to indicate patient can be referred elsewhere.
Consultation	Select appropriate box(es) to indicate what follow-up is desired.
Referral	Select to transfer management of the patient problem to the referral physician and request visit summaries.
Signature	Check *Use my Signature Bitmap* to use your electronic signature on the letter or form.

Screen Element	Action
Checkboxes (Follow-up)	At the bottom of the screen, select as many of the checkboxes as appropriate to indicate follow-up reporting desired.
Reason for consultation/referral	Enter the reason for the patient referral/consultation into the text box using conventional word-processing tools.

5. Click the **Letter** tab to view the letter.



6. To select the items you want to include with the letter, in the upper left corner, do the following:
   - Click to check or uncheck the sections of the H&P as wanted ***or***
   - Click **Check All** and then uncheck sections you don't want included ***or***
   - Click **Uncheck All** and then check sections you want to include (if any).

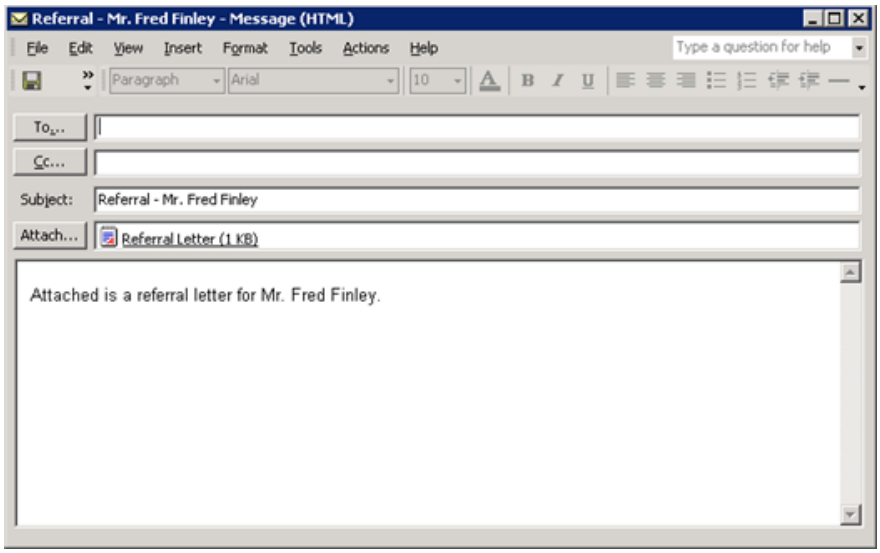
     NOTE: This box populates with the documentation available in the patient chart.

7. To send the referral, do one of the following:
   - **Print or fax** - To print or fax the letter, click **Print**, then **OK** in the Print dialog.

     NOTE: To fax, the printer must be set to *Always prompt* so you can select the fax printer. See Editing output defaults on page 130.

8. **To email the referral letter** via Outlook Email (**IF** MS Outlook is set up for emailing out of HealthMatics EMR), click **Email** to display Choose Profile.

- At *Profile Name,* select a profile and click **OK** to display the email form.

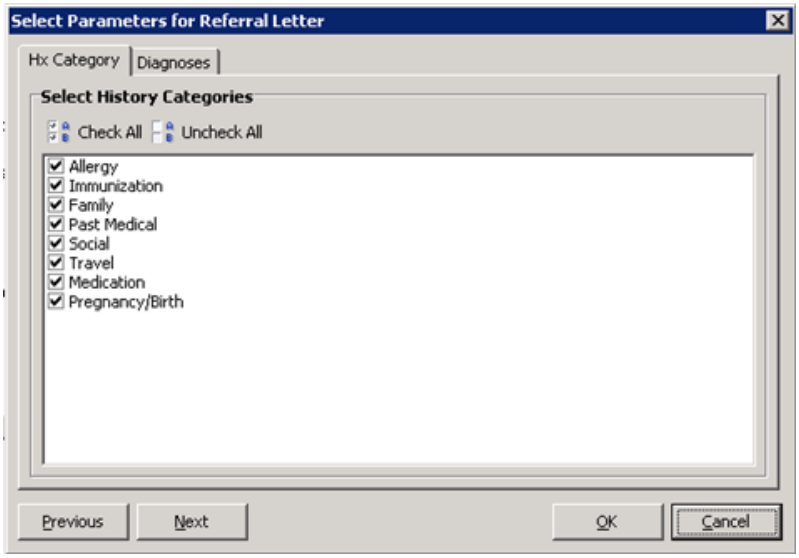


- Send the email as you would any other from Outlook.
  The subject is provided and the referral letter shows as an attachment.

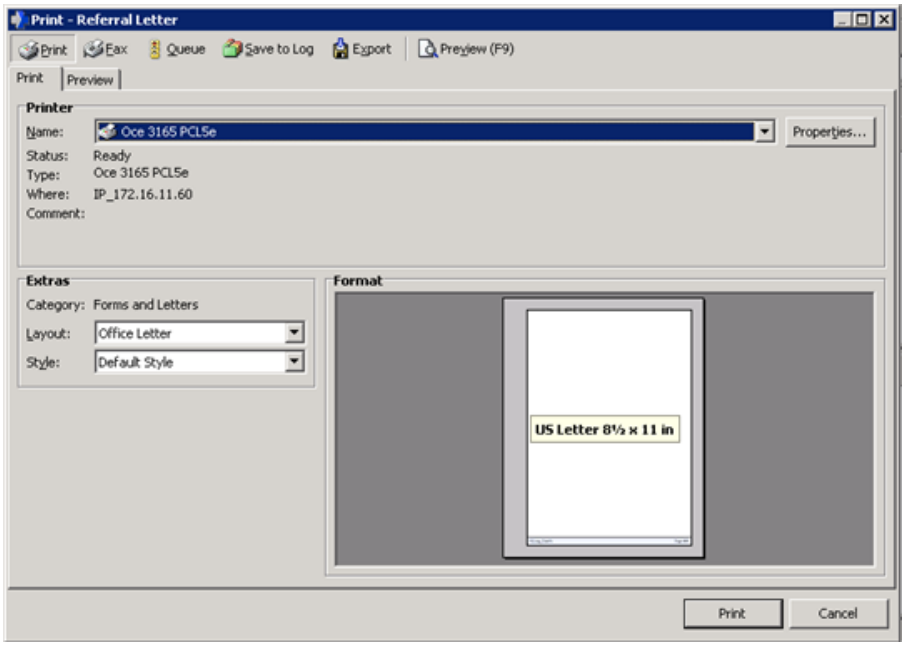
  NOTE: Ensure appropriate encryption prior to emailing patient information.

Option 3 - Select referral letter from patient chart

1. With a patient chart open, from the HealthMatics EMR Menu bar, click **Print > All Templates > Forms and Letters > Referral Letter** after documenting the pertinent encounter information, or select a template from your customized list.



2. Select items to include in the letter from the available tabs.
3. Click **OK**.
4. Complete the Print -Referral Letter selections and preview as necessary.



5. Click **Print** (**Fax**, **Queue**, **Save to Log** or **Export**) to complete the process.

Using authored text in assessment/plan

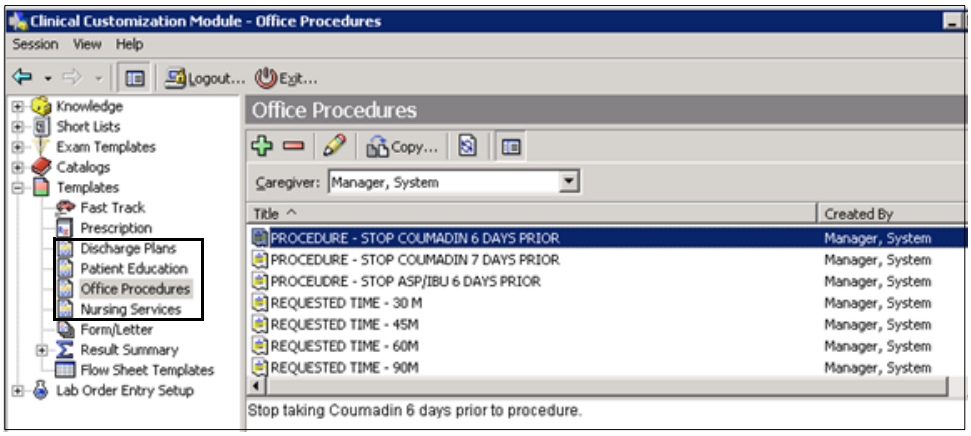
You can use authored text to create standard documentation such as counseling, post-op or procedure instruction, discharge plans, and so forth. Refer to the HealthMatics EMR ***Clinical Customization*** manual for information on how to create practice-specific Authored text.

1. Open a patient chart, and from the left pane ***or*** the toolbar, click **A/P** (Assessment/Plan).
2. From a short list or the Search tab, locate the Authored text item.
3. Double-click it to add it to the encounter lower pane.
4. Authored text (unless marked with a status of *complete*), displays as *pending* and appears on the Additional Results tab for follow up.

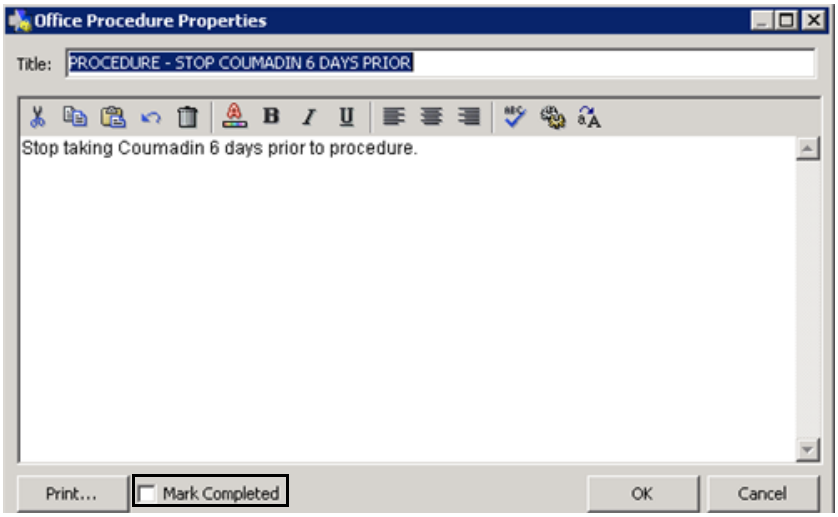
Setting patient authored text templates to *completed* in A/P

You can set the default status for patient authored text templates to *Completed* and therefore not have to open each item in Assessment/Plan to mark it complete.

1. From the HealthMatics EMR menu, select **Launch > Clinical Customization Module**
2. Click **(+)Templates**, then select one of the patient authored text template categories (**Discharge Plans, Patient Education, Office Procedures,** or **Nursing Services**) to display the authored text templates on the right.



3. Double-click an authored text item ***or*** select it and click to display Authored Text.



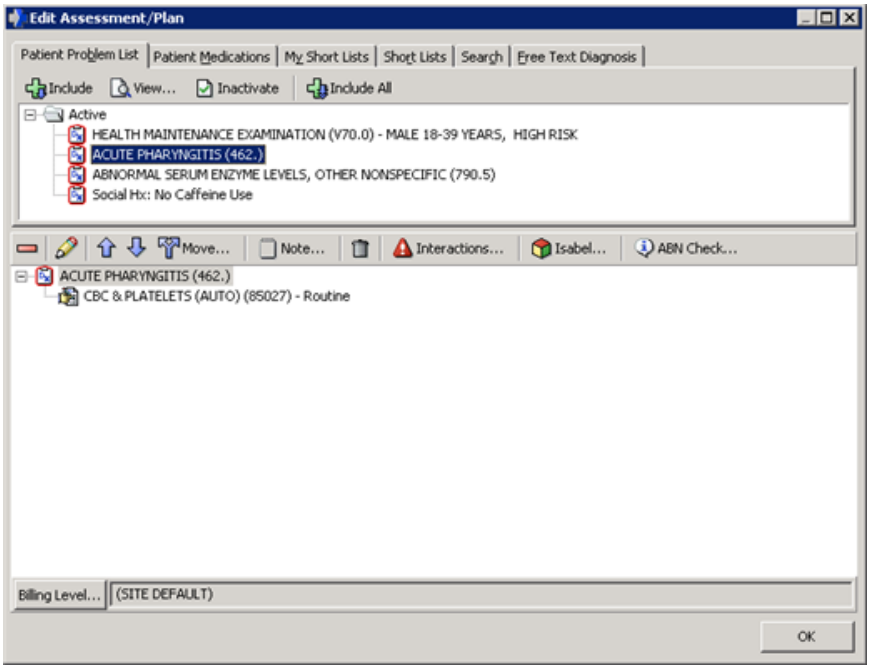
4. Click **Mark Completed** and then **OK**.

5. Repeat steps for other patient authored text templates to default them to *Completed* in Assessment/Plan.

Displaying quick assessment/plans

Add a quick assessment and plan from any contact window at any time during an encounter without leaving the window you are documenting.

1. Open a patient chart, and on the toolbar, click (Quick Assessment/Plan) to display Edit Assessment/Plan **on top** of other contact windows, such as History.



2. Add assessment and plan data as you would with the full Assessment/Plan window. (see Specifying assessments and plans on page 292).
3. Click **OK** to return to the previous window.

Pregnancy Record

Use the Pregnancy Record to document antepartum records used in both American College of Obstetricians and Gynecologists (ACOG) and Hollister forms through a single point of entry. Information added through the Pregnancy Record is saved and populates appropriate clinical module screens in the HealthMatics EMR. Documents entered in HealthMatics EMR that relate to the Pregnancy Record populate the Pregnancy Record.

You can enter the Pregnancy Record from the HealthMatics EMR menu bar or from *Patient Manager*. When you first enter the Pregnancy Record, you're asked for the *Last Menstrual Period* (LMP) or *Estimated Delivery Date* (EDD). The application uses this date to decide what information to display, based on the expected gestational period for the pregnancy.

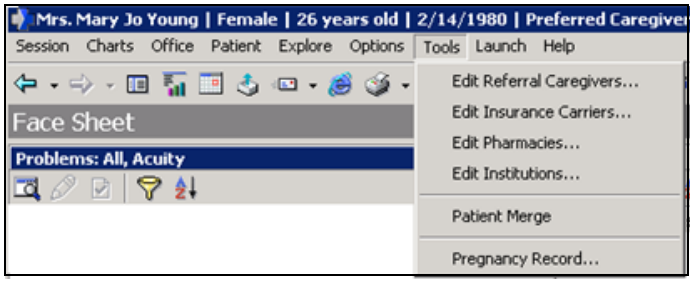
The Gestational Age calculates automatically for open encounters by using the *EDD by Physician* if entered, or otherwise the LMP date. The calculated Gestational Age appears in Patient Manager, the Pregnancy Record main window, the Prenatal Record grid and the Maternal/Fetal Data tab.

Accessing the pregnancy record

To access the Pregnancy Record, both requirements below are needed:

- A patient chart must be pulled
- An active 59400 procedure (using the OB-Antepartum tool) must be selected in Assessment & Plan (A&P) for the encounter.

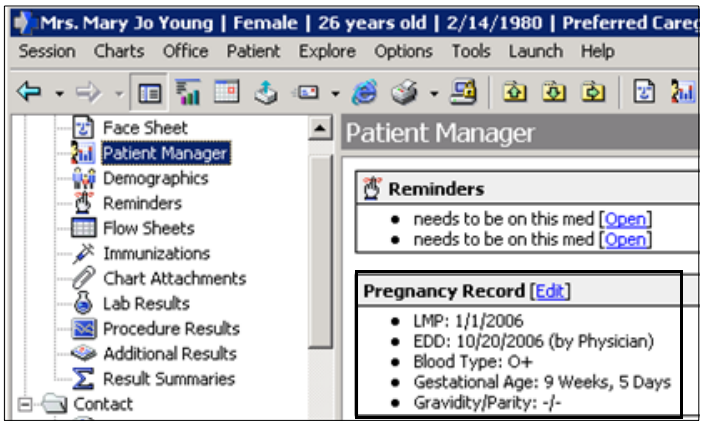
1. With a patient chart open, click **A/P** and order the 59400 Routine Obstetric Care procedure.
2. From the HealthMatics EMR menu, click **Tools > Pregnancy Record**.



NOTE: If the encounter does not have an active 59400 CPT, a warning message displays. Click **OK**, then add the 59400 Routine Obstetric Care procedure through A&P.

3. **Additional pregnancy record access option** available from Patient Manager

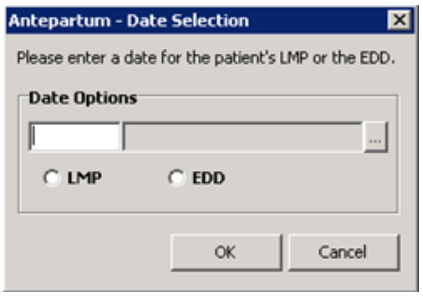
   - From HealthMatics EMR left navigation pane, and with a patient chart with an active 59400 rule open, click **Patient Manager**.



Patient Manager Pregnancy Record (Edit)	
LMP	Last Menstrual Period date displays once value is populated.
EDD	Estimated Delivery Date based on LMP or entered by physician.
Blood type	Populates from Pregnancy Record until lab confirms, then from Lab data.
Gestational age	Calculated value from EDD By Physician if entered or LMP. If the Gestational Age changes on the Maternal/Fetal Data tab, the change is immediately reflected on the Pregnancy Record main window, the Prenatal Record grid and the Maternal/Fetal Data tab.
Gravidity/parity	Number of pregnancies/Number of live births

4. The first time you enter the Pregnancy Record with an active 59400 rule, it checks for either an Estimated Delivery Date (EDD) or Last Menstrual Period (LMP) date.

If neither date is found, the Antepartum - Date Selection dialog appears.



Field/Icon/Button	Action
Date options	Enter either an LMP ***or*** EDD date. (See below) Data displays within a particular time frame, namely the gestational period for the current pregnancy. A valid date generates the text representation of the date, such as *(7 weeks ago)*.
	Click ellipse icon to display a calendar to allow full or partial date selection.
LMP	Last Menstrual Period date Date entered populates both Vitals in EMR and the Maternal/Fetal Data tab.(Cannot be a future date.) ***or***
EDD	Estimated Delivery Date Date entered used to populate the Procedure Rule in EMR and the Maternal/Data tab. (Cannot be a past date.)

NOTE: The LMP date is queried from Vitals in the HealthMatics EMR.
The LMP and/or EDD date entered is added to the Pregnancy Record, Vital Signs, and H&P Report when you click **OK**.

5. Enter the appropriate date, click either **LMP** (Last Menstrual Period) or **EDD** (Estimated Date of Delivery), then click **OK**.

   NOTE: To access previous encounters once within the Pregnancy Record, from the HealthMatics EMR menu, click **Explore > Encounters** and select the encounter to view.

Documenting with the pregnancy record

The Antepartum Record is the main window for the Pregnancy Record and includes a dated list of relevant antepartum visit records in the top pane. The LMP or EDD date is used to calculate which records fall within the current pregnancy (EDD minus 280 days). Previous pregnancies are not displayed (those prior to the LMP).

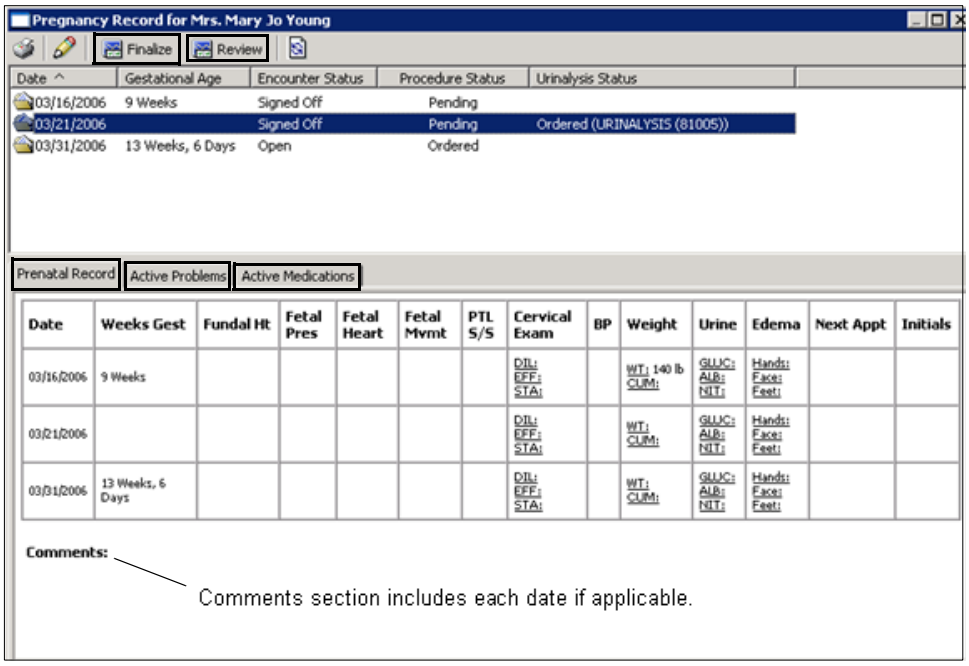
The lower section of the main window includes a tab selection of summary screens:

- **Prenatal records** - Displays a row for each 59400 rule documented.

  NOTE: Cannot edit the 59400 detail when the encounter is signed-off.

- **Active problems** - Lists all active problems for the patient
- **Active medications** (from the EMR) - Lists all active medications for the patient

1. Access the Pregnancy Record (see Accessing the pregnancy record on page 322).
2. To document the current encounter, select the current date in the top pane and double-click or click ., then click tabs as needed to document the visit (see Editing pregnancy record screens on page 326).

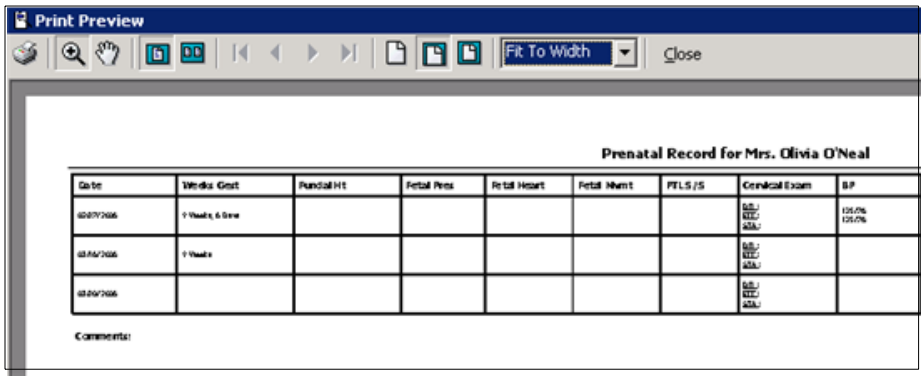


NOTES

* CPT 59400 procedure can be reviewed and finalized from the Pregnancy Record in the same way as in the Procedure Results screen in the EMR. Once the procedure is *Final, Reviewed* status, the procedure data in the Pregnancy Record is read-only. However, other tabs not related to the procedure are still editable.

* The CPT 59400 Procedure Entry Rule cannot be customized.

3. Click to open the Prenatal Record in the Print Preview window.



Icon	Action
	Print document
	Zoom document to larger view
	Move document in window view
	View one page
	View two pages
	Zoom to 100%
	Zoom to fit page width
	Zoom to fit whole page
Fit To Width	Customize choice drop-down list
Close	Close window

4. **(Optional)** Click to refresh data on the Main Window.

Editing pregnancy record screens

Edit/add information for each pregnancy record screen as needed. When a caregiver selects , the first screen, Vital-UA (default tab) displays.

Pregnancy Record screens include:

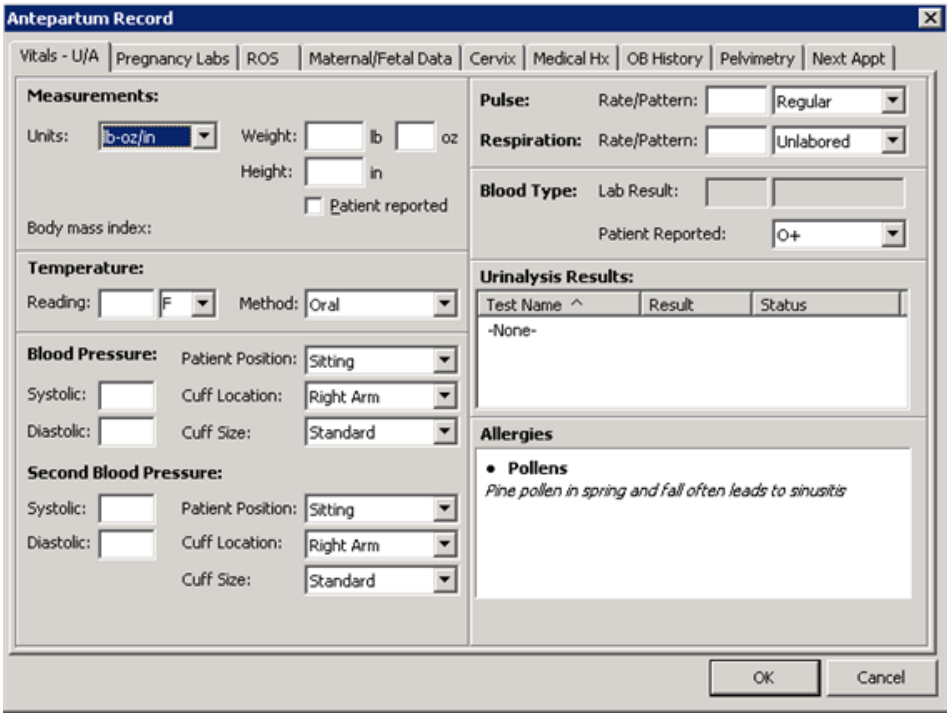
- **Vitals - UA** - Data bidirectional between Pregnancy Record, Vital Signs, Lab results, and Allergy History
- **Pregnancy Labs** - Includes tab results available in the EMR. Results can be filtered based on LMP date.
- **ROS** - Data bidirectional between Pregnancy Record and ROS
- **Maternal/fetal data** - Data bidirectional with Pregnancy Record and 59400 Procedure Rule/View Procedure Results
- **Cervix** - Data bidirectional with Pregnancy Record and 59400 Procedure Rule/ View Procedure Results

- **Medical Hx** - Data writes to Pregnancy History in the History window and is bidirectional with Medical HX in the patient encounter
- **OB history** - Data writes to Pregnancy History in the History window and is bidirectional with OB History in the Pregnancy Record
- **Pelvimetry** - Data bidirectional between the Pregnancy Record and the 59400 Procedure Rule/View Procedure Results
- **Next appt** - Data bidirectional between the Pregnancy Record and the 59400 Procedure Rule/View Procedure Results

To edit pregnancy record vitals - U/A

1. Access the Pregnancy Record (see Accessing the pregnancy record on page 322).

2. Select a visit date and press **F2** ***or*** click (Edit Record).



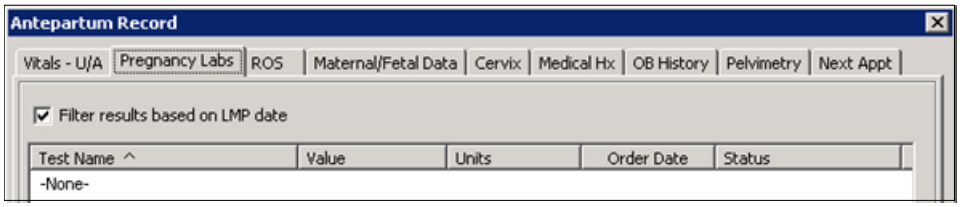
Field	Action
Weight	Enter weight (numeric) and select either pounds (lb) or kilograms (kg). Default method can be set up as a caregiver option. **NOTES** • This information can also be documented in Vital Signs . • *Cumulative Weight Gain* calculates from the first weight entered.
Pulse/respiration	Enter numeric values. Rate and pattern descriptors are caregiver options or selected from drop-down menu.
Temperature	Enter numeric value and select either Fahrenheit or Celsius values. Default reading and method can be set in caregiver options. Drop-down menu selection includes: *Oral, Tympanic, Rectal,* and *Axillary*.

Field	Action
Blood type	• Data is bidirectional between Demographics and Patient Reported. Drop-down default is *Undefined*. Other selections include all other blood types. • *Lab* - RH Blood Typing (86901) and ABO Blood Typing (86900) but both have to be ordered. These are included in the Obstetric Panel. Once resulted, the lab data populates the Pregnancy Record.
Blood pressure	Enter blood pressure. Descriptors are caregiver options or selected from drop-down menu.
Second blood pressure	Enter second blood pressure reading if indicated.
Urinalysis results	Reports urinalysis results from any of the following: 81000, 81002, 81001, 81003, 80055.
Allergies	Reports from History - Allergies

3. Complete fields as necessary.
4. Click **OK** to save and validate all data in the edit window.
5. **(Optional)** Click **Cancel** if you do not want any data saved from the edit.

To access pregnancy record pregnancy labs

1. Access the Pregnancy Record (see Accessing the pregnancy record on page 322).
2. Select a visit date and press **F2** ***or*** click (Edit Record).
3. Click **Pregnancy Labs** tab

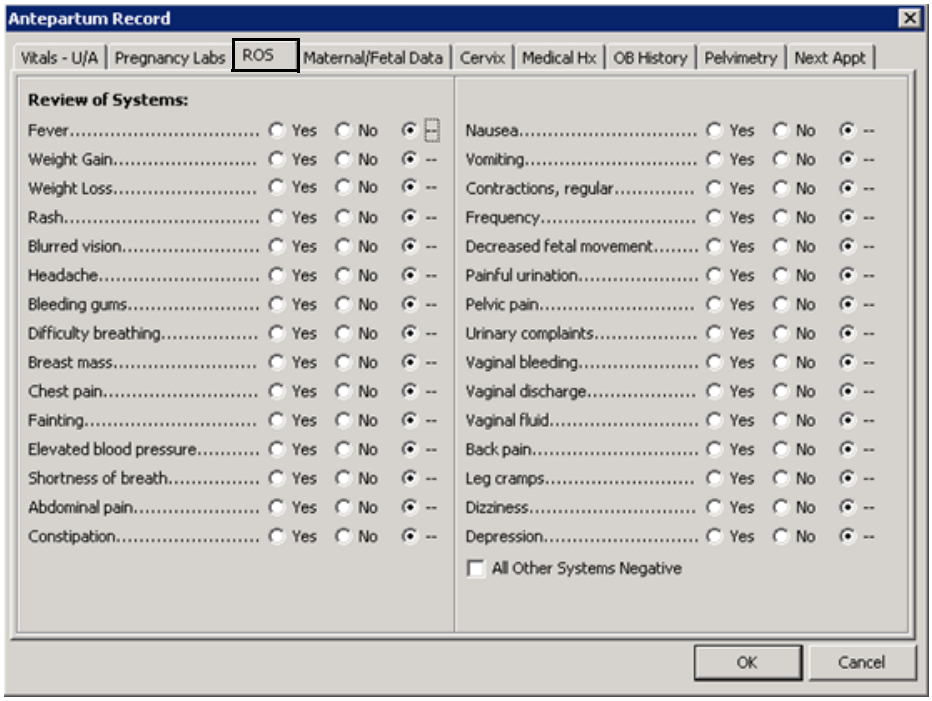


NOTES
* Labs resulted in the EMR display on this tab.
* Click any header tab to sort the lab.
* Check **Filter results based on LMP date** to view labs pertinent only to this pregnancy.

To edit pregnancy record review of systems

NOTE: This information is bidirectional between *Review of Systems* ( ) and Pregnancy Record.

1. Access the Pregnancy Record (see Accessing the pregnancy record on page 322).
2. Select a visit date and press **F2** ***or*** click (Edit Record).
3. Click the **ROS** tab.



NOTE: If you have applied a template or documented on the ROS Contact Screen, those values populate the ROS tab in the Pregnancy Record.

4. Click each radio button for each symptom as required.

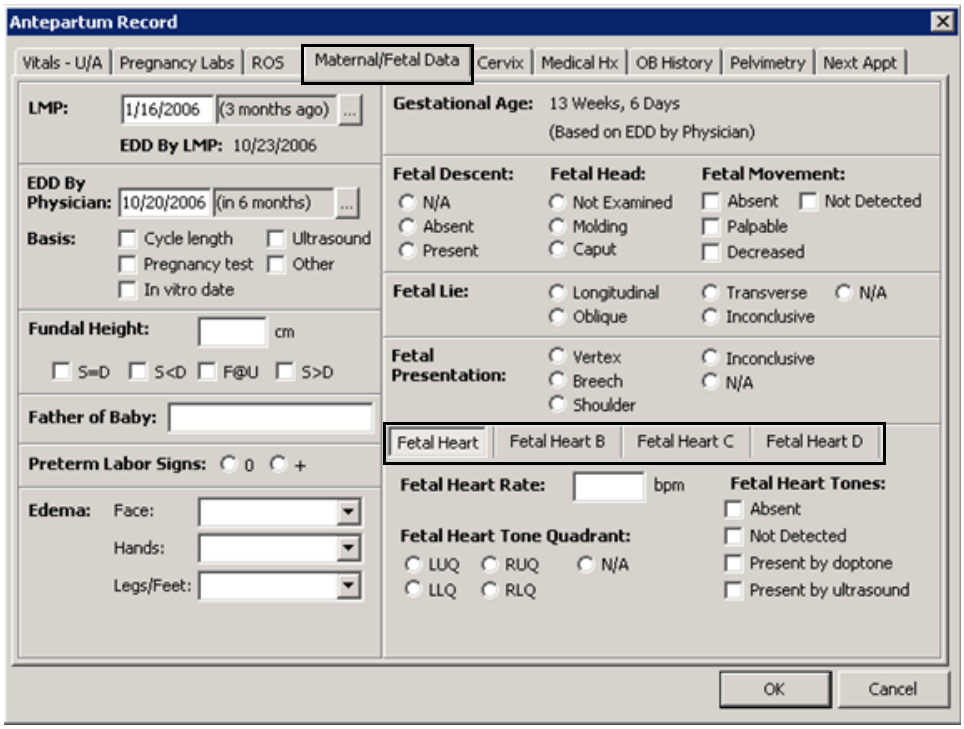
   IMPORTANT! The third radio button for each item resets the answer to nothing.
5. Click **OK** to save and validate all data in the edit window, or go to the next tab to continue documenting (data is not automatically saved).
6. **(Optional)** Click **Cancel** if you do not want any data saved from the edit.

To edit pregnancy record maternal/fetal data

NOTE: This information is bidirectional with the 59400 Routine Obstetric Care Procedure Rule/View Procedure Results.

1. Access the Pregnancy Record (see Accessing the pregnancy record on page 322).
2. Select a visit date and press **F2** ***or*** click (Edit Record).

3. Click **Maternal/Fetal Data** tab.



4. Complete each data field as required.

   NOTES
   * The **LMP** date is bi-directional with the VS Contact Screen as well as the 59400 Routine Obstetric Care Procedure Entry Rule.

   *** Fetal Heart** allows for multiple fetuses (1-4).

5. Click **OK** to save and validate all data in the edit window, or go to the next tab to continue documenting (data is not automatically saved).

6. **(Optional)** Click **Cancel** if you do not want any data saved from the edit.

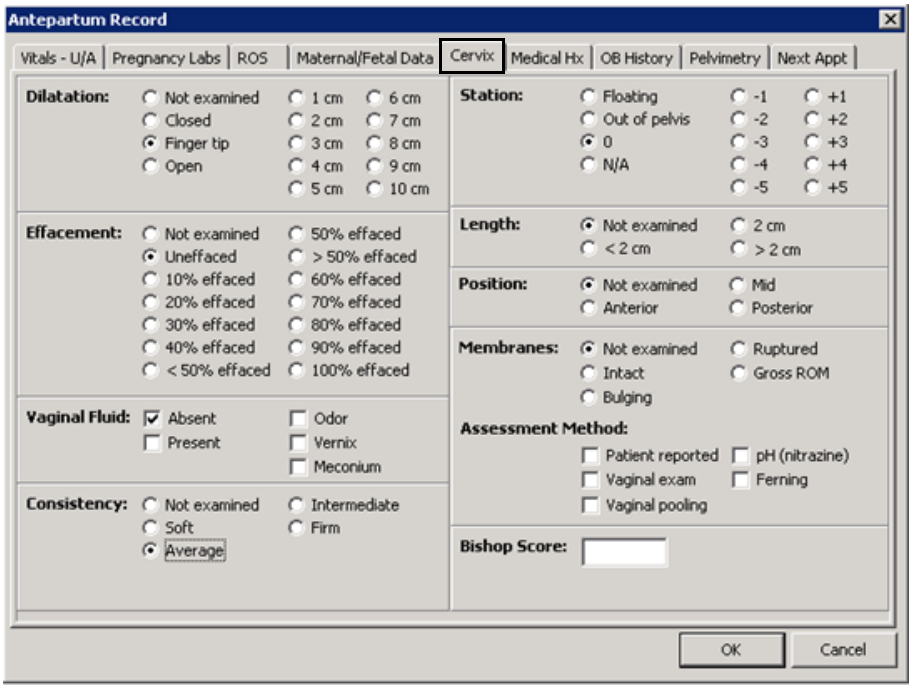
To edit pregnancy record cervix

NOTE: This information is bidirectional with the 59400 Routine Obstetric Care Procedure Rule/View Procedure Results.

1. Access the Pregnancy Record (see Accessing the pregnancy record on page 322).

2. Select a visit date and press **F2** ***or*** click (Edit Record).

3. Click **Cervix** tab



4. Complete each data field as required.
5. Click **OK** to save and validate all data in the edit window.
6. **(Optional)** Click **Cancel** if you do not want any data saved from the edit.

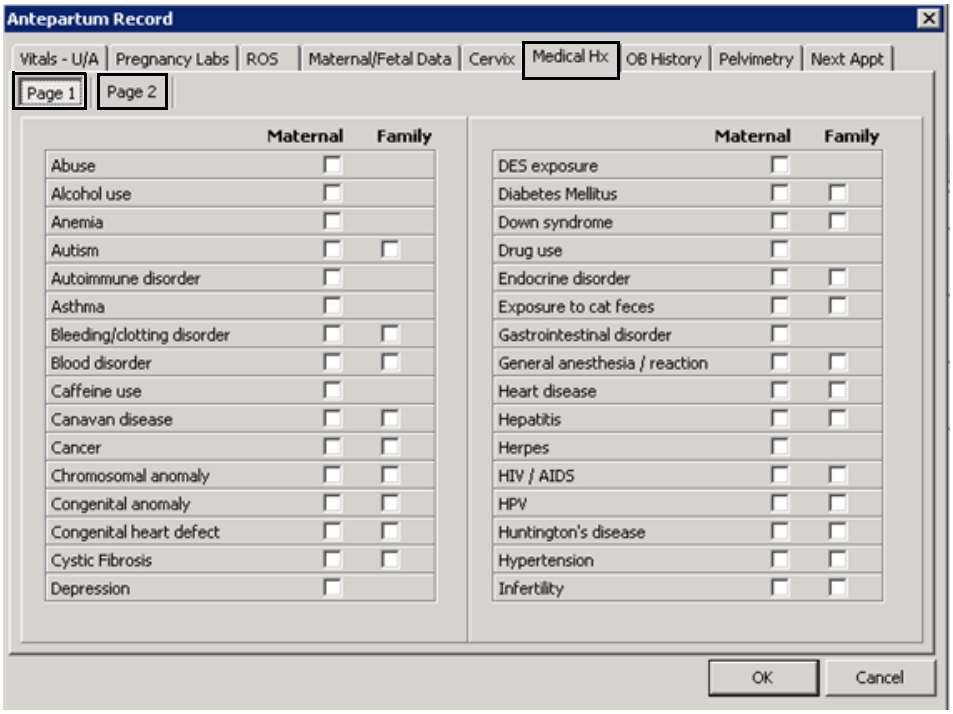
NOTE: The Bishop Score does not calculate automatically.

To edit pregnancy record medical Hx

NOTE: The two screens of Information documented here are bidirectional with the History ( ) Contact Screen - Pregnancy/Birth History.

1. Access the Pregnancy Record (see Accessing the pregnancy record on page 322).
2. Select a visit date and press **F2** ***or*** click (Edit Record).

3. Click **Medical Hx** tab.



4. Complete each of the two data screens as required.
5. Click **OK** to save and validate all data in the edit windows.
6. **(Optional)** Click **Cancel** if you do not want any data saved from the edit.

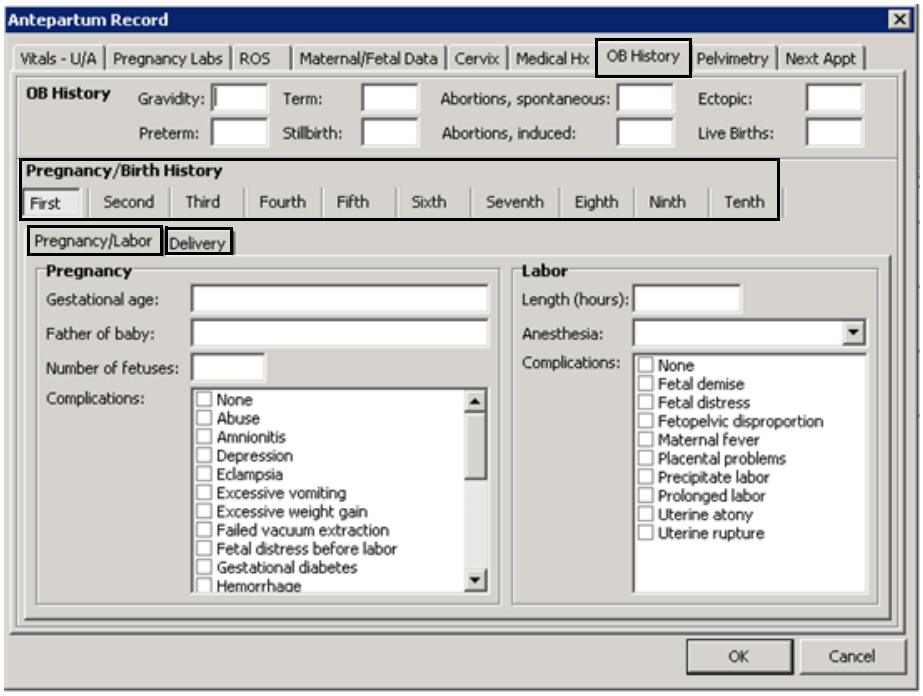
NOTE: If you choose to document on the History Contact Screen, access Pregnancy/ Birth History and use the selection Maternal Past Medical History and Family History selections.

To edit pregnancy record OB history

NOTE: Information documented here is bidirectional with ( ), and writes to Pregnancy history in History

1. Access the Pregnancy Record (see Accessing the pregnancy record on page 322).
2. Select a visit date and press **F2** ***or*** click (Edit Record).

3. Click **OB History** tab.



4. Complete the data screens as required.

   NOTES
   * **Pregnancy/birth history** is available for multiple pregnancies (1-10)

   * Two tabs are available from this screen:
   Pregnancy/Labor Tab - Details information about the Pregnancy/Labor
   Delivery Tab - Details Delivery information

   * This information can be documented also in **Pregnancy/Birth History > Maternal Past Medical History 1- 0**.

5. Click **OK** to save and validate all data in the edit windows or go to the next tab to continue documenting (data is not automatically saved).

6. **(Optional)** Click **Cancel** if you do not want any data saved from the edit.

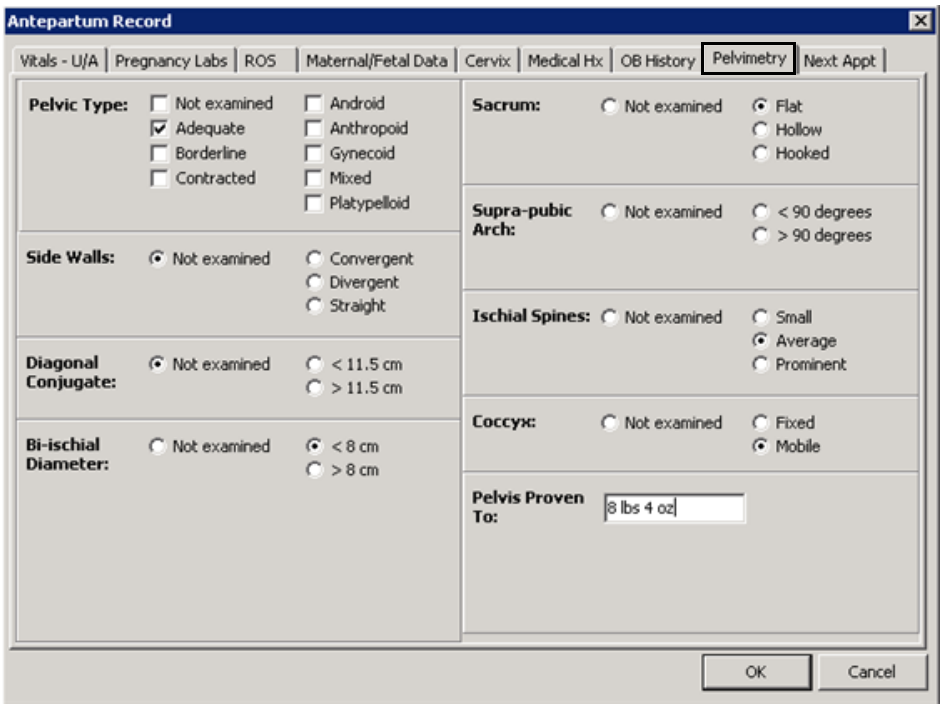
To edit pregnancy record pelvimetry

NOTE: This information is bidirectional with the 59400 Routine Obstetric Care Procedure Rule/View Procedure Results. Also responses documented in PE/Female Genitourinary/Obstetric Exam/Pelvimetry will populate this screen.

1. Access the Pregnancy Record (see Accessing the pregnancy record on page 322).

2. Select a visit date and press **F2** ***or*** click (Edit Record).

3. Click **Pelvimetry** tab.



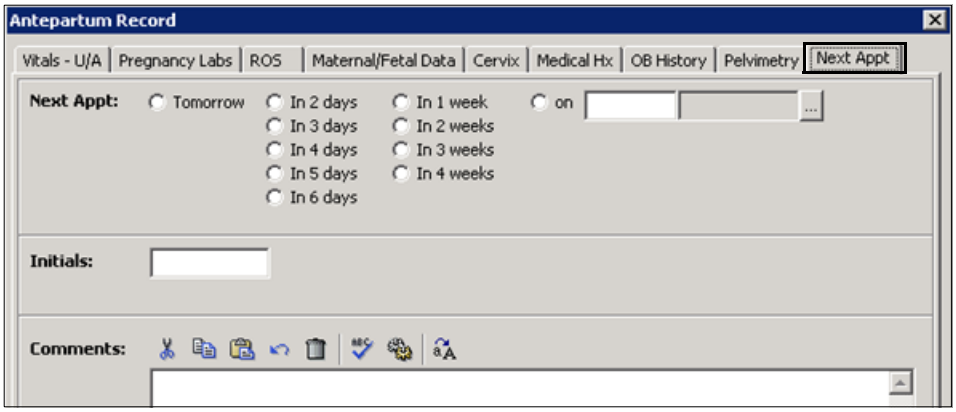
4. Select each checkbox/radio button data field as required.
5. At *Pelvis Proven to:* enter pounds and ounces of the largest baby the patient delivered.
6. Click **OK** to save and validate all data in the edit window or go to the next tab to continue documenting (data is not automatically saved).
7. **(Optional)** Click **Cancel** if you do not want any data saved from the edit.

To edit pregnancy record next appointment

NOTE: This information is bidirectional with the 59400 Routine Obstetric Care Procedure Rule/View Procedure Result.

1. Access the Pregnancy Record (see Accessing the pregnancy record on page 322).
2. Select a visit date and press **F2** ***or*** click (Edit Record).

3. Click **Next Appt** tab.



4. Complete **Next Appt** as required.
5. Enter initials.

   NOTE: This field can hold initials of multiple caregivers.

6. At *Comments*, use conventional word-processing tools to add information as desired. Comments are dated and display below the Pregnancy date grid.
7. Click **OK** to save and validate all data in the edit window.
8. **(Optional)** Click **Cancel** if you do not want any data saved from the edit.

Including unsolicited test results in pregnancy records

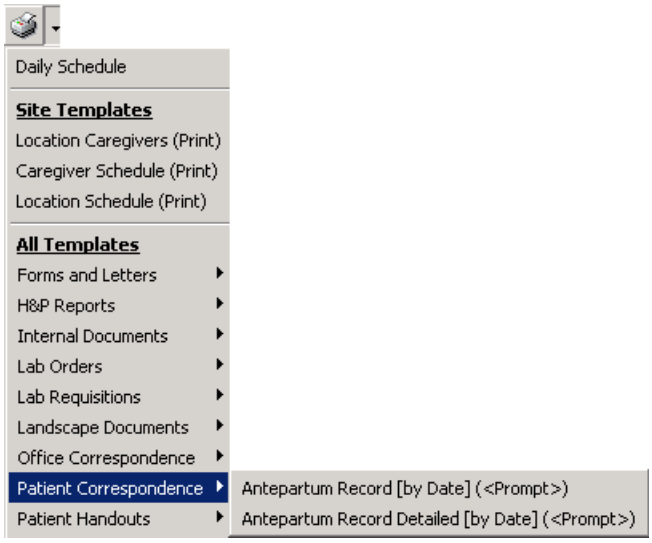
To ensure unsolicited reflex tests (a secondary test performed by the lab based on the results of the initially ordered test) are included in pregnancy records, print the record before staff merges the unsolicited test with results from the original order. The unsolicited test results are automatically included in the record.

Printing the pregnancy record

Output Manager provides a template of output blocks by Date to ensure all test and procedure results related to the pregnancy are included in the Pregnancy Record. For details, see the HealthMatics EMR ***Output Manager*** manual.

1. From the HealthMatics EMR menu, click the **Print** drop-down arrow.
2. From **All Templates > Patient Correspondence**, click the version of the Antepartum Record to print. (You can also customize to make these templates display under

the *Site, Location* or *My Templates* sections.)

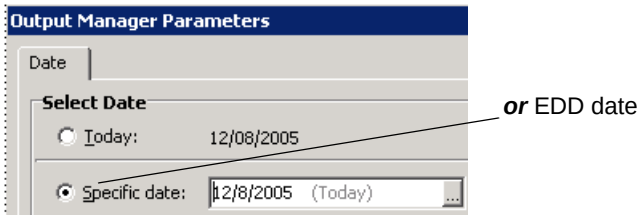


NOTES

* When you select the Antepartum template, the application prompts for a date and provides two radio button choices (**Today** and **Specific date**) before printing the Pregnancy Record.

* The *Today* date (default) subtracts 280 days from today's date. Items are pulled to the record based on this time frame. The date is not diagnosis-specific but date-driven.

* If you enter a *Specific date* (this should be the EDD date), the application counts back 280 days from the date and includes all test/procedure results within that date range.



3. The Print Properties window displays (see Printing patient demographics on page 166 for more print property information).

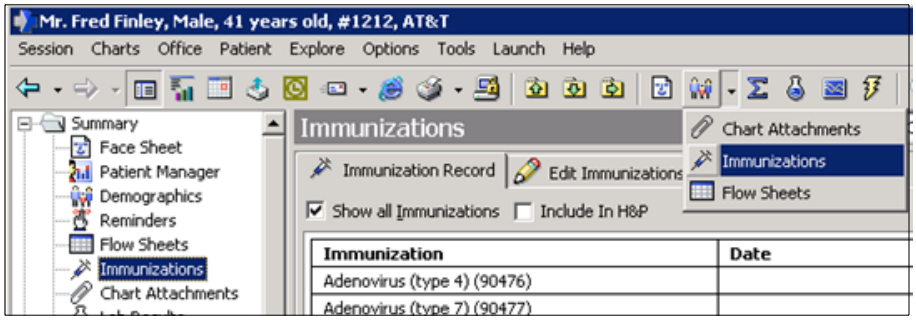
Immunization Records

When you order immunizations in HealthMatics EMR, they are recorded automatically in the Immunization Record. In Immunization History, you can also record the overall status of patient immunizations.

Accessing/viewing Immunization Record

Immunizations entered into HealthMatics EMR are captured in an Immunization Record that can be previewed, included in the A/P, and printed to give to patients.

1. Open a patient chart, and from the left pane select **Immunizations *or*** from the HealthMatics EMR toolbar, click the Demographics down-arrow ( ) and select **Immunizations**.



The Immunization Record tab with the **Show all Immunizations** checkbox selected, is the default view.

Immunization Record tab	
Show all Immunizations checkbox	Default - This view displays all possible immunizations and date fields. Deselect the checkbox to view immunizations specific to this patient.
Include In H&P	Select to include the Immunization Record in History and Physical.

NOTES

* Immunizations ordered in Assessment/Plan are automatically recorded in the immunization table according to the data on record.
Example: If a record shows the date of DTP #1 on 12/28/2004 and another DTP is ordered on 3/28/2005, it automatically populates in the DTP #2 slot. You can change this information through editing in A/P or from the Edit Immunizations tab.

* If the immunization record entered into HealthMatics EMR is incomplete
Example: Earlier immunizations were given but not recorded in EMR, when an immunization is ordered, it will populate the first available slot for the series. If this occurs, the record can be edited (see Editing immunization history on page 339).

2. Click the **Edit Immunizations** tab to edit immunizations.

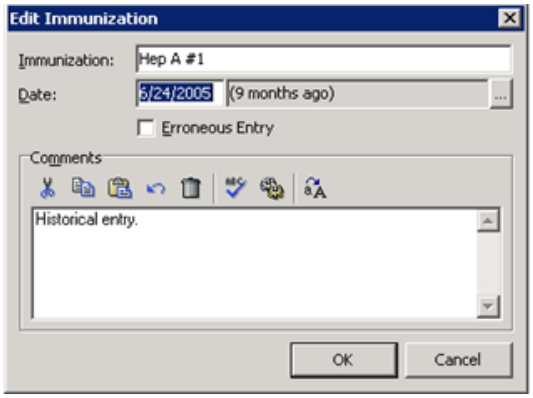
Editing immunization history

To edit existing immunization history

1. Access Immunizations (see (Accessing/viewing Immunization Record on page 338).
2. Click the **Edit Immunizations** tab.

Icon	Action
Add Historical	Add historical immunization information.
Show Erroneous	Default view - Deselected Click checkbox to display erroneous immunization entries. **NOTE:** Erroneous entries appear grayed-out with a line through them.

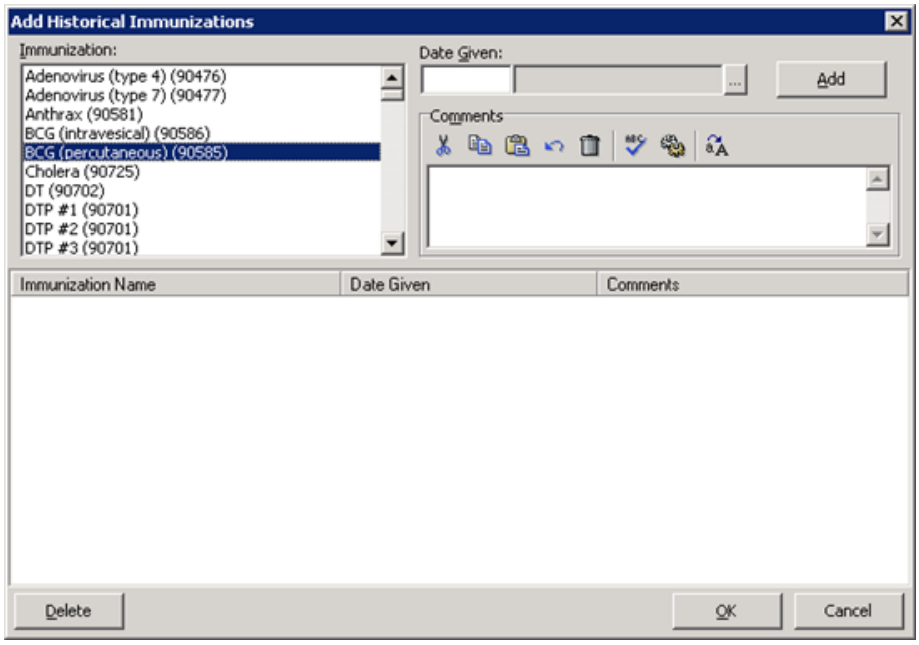
3. Select the immunization you want to edit and do **one** of the following:
   - Press **F2** ***or***
   - Double-click the immunization ***or***
   - Click (Edit Immunizations) ***or***
   - Right-click and choose **Edit**.



4. Make any of the following changes:
   - Change the date
   - Mark the immunization **Erroneous Entry**.
   - Add a comment (using conventional word-processing tools)

To add historical immunizations

1. Access Immunization (see Accessing/viewing Immunization Record on page 338).
2. Click the **Edit Immunizations** tab.
3. Click **Add Historical**.



4. Click the Immunization name and CPT code from the *Immunization* window in the left upper pane.

   NOTE: You can multi-select by using **Ctrl+Click**.

5. At *Date Given*, select a date.

   NOTE: This date is entered for all immunizations selected but can be edited later.

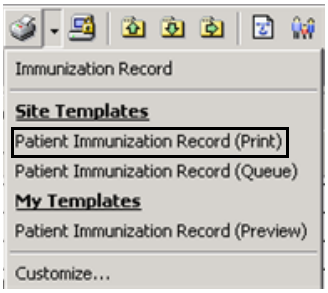
6. At Comments, enter any comments.

   NOTE: Comments will be entered for all immunizations selected.

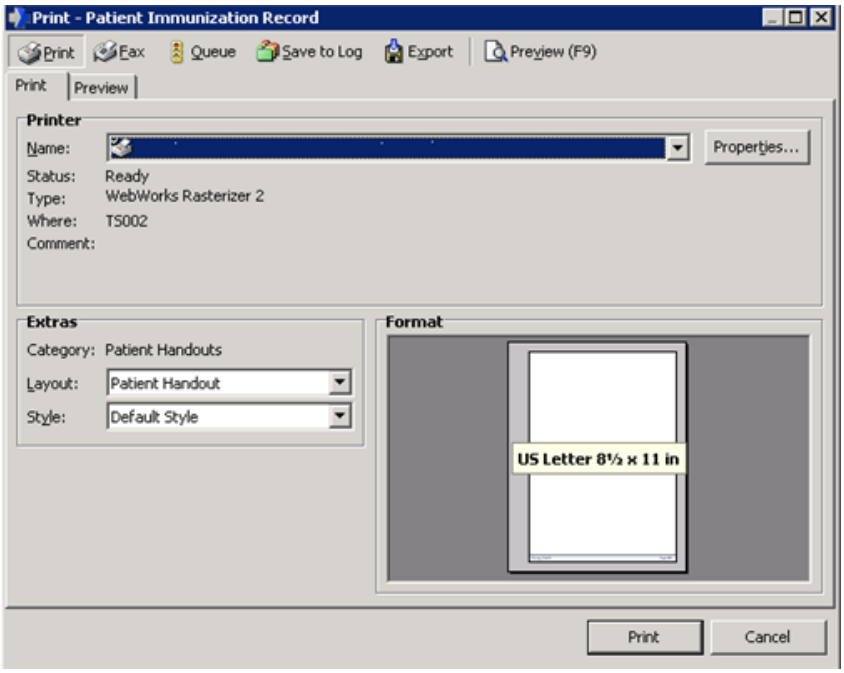
7. Click **Add** for selected immunizations to display in the bottom pane.
8. If necessary to remove an immunization, highlight the immunization in the bottom pane and click .
9. To exit without saving changes, click **Cancel**.
10. When Historical Immunization entry is complete, click **OK** to exit and save.
11. Edit entries as needed (see Editing immunization history on page 339).

Printing immunization record

1. Access Immunization Record (see Accessing/viewing Immunization Record on page 338).
2. From the HealthMatics EMR toolbar, click .



3. Click **Patient Immunization Record**.



4. Select **Printer**, **Layout** and **Style** as needed.
5. **(Optional)** Click the **Preview** tab to review how the Immunization Record will print. (For information about Preview tools, see Documenting with the pregnancy record on page 325, step 3.)
6. Click **Print**.

Ordering and documenting immunizations

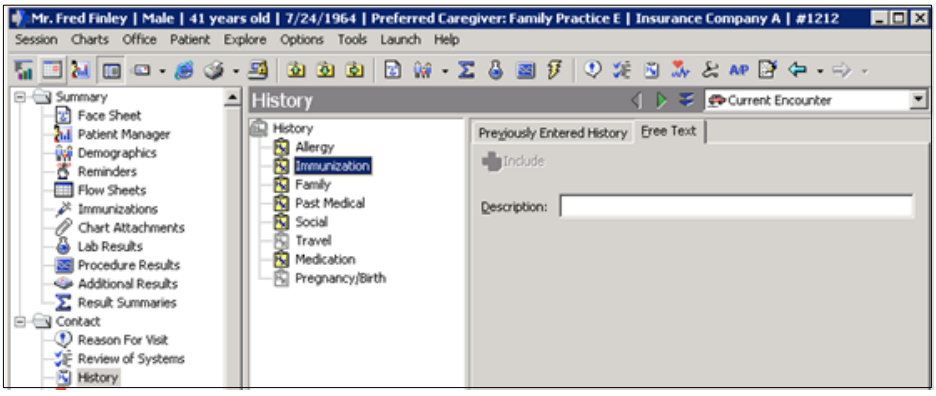
1. Open a patient chart, and from the left pane ***or*** the toolbar, click **A/P** (Assessment/ Plan).
2. Search for and select an immunization and do **one** of the following:
   - Double-click it ***or***
   - Click **Include** ***or***
   - Right-click and select **Include** ***or***
   - Drag and drop it to the preview (bottom) pane
3. Do the same for the appropriate injection administration code.
4. From the left pane ***or*** the toolbar, click (Procedure Results) to complete the clinical administration, that is, location, lot #, and so forth.
5. The Immunization name and administration date transfers to the Immunization Record automatically.

Documenting immunization status

You can now enter the patient immunization status using one-click entry of *Up to Date* or *Not up to Date* in *Immunization* History.

To enter other free text immunization history

1. Open a patient chart, and from the left pane or toolbar, click (History).
2. In the *History* folder tree, select **Immunization** and click the **Free Text** tab.



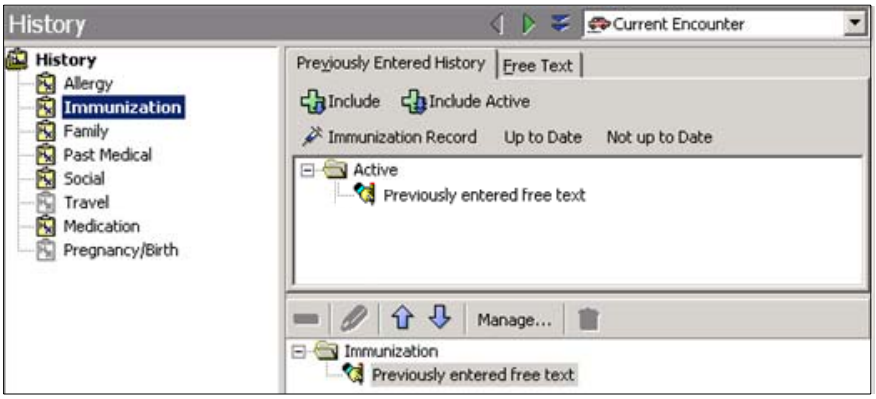
3. At *Description*, enter the immunization text.
4. Click **Include** and **OK** to return to the Immunization History screen.

To document immunizations using previously entered free text

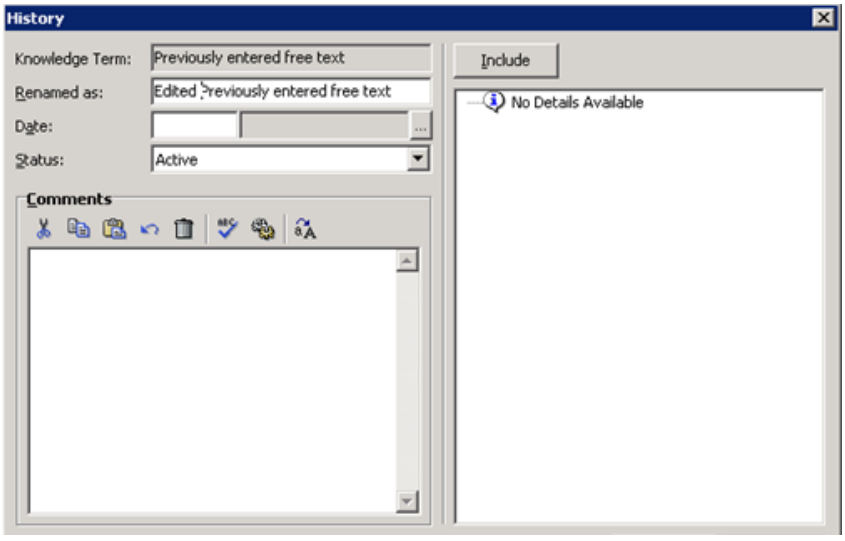
You can use one free text entry multiple times editing it as needed to reflect the current condition. This prevents a long list of disconnected free text items from accumulating in the patient history list.

You can also enter multiple free text items as needed.

1. Open a patient chart, and from the left pane **or** the toolbar, click (History).
2. In the *History* folder tree, select **Immunization** and the **Previously Entered History** tab.



3. Add the free text item to the current encounter by doing one of the following:
   - Double-click it ***or***
   - Select it and click **Include** ***or***
   - Right-click it and select **Include** ***or***
   - Click and drag it to the preview (lower) pane.
4. To edit the free text item, select it in the preview (lower) pane and click (Edit Selected Item) ***or*** double-click it.



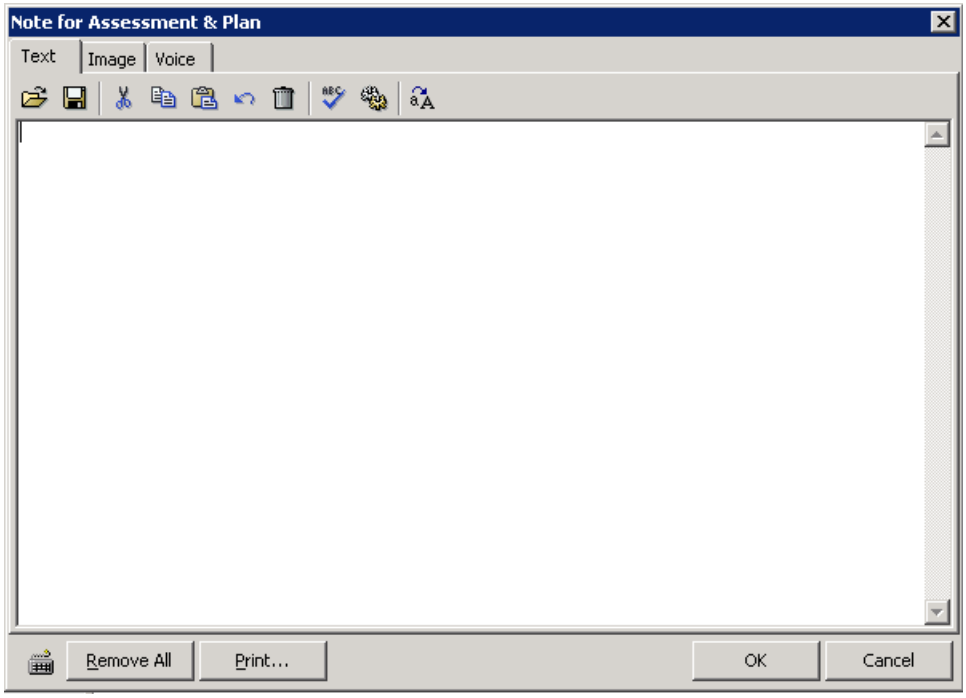
5. At *Renamed as*, change the text of the item. (**Example:** “Edited Previously used free text.”)

6. Click the **Date** search button, select **Full Date**, then to accept today's date (circled in red on the calendar), click **OK**.
7. Click **OK** to return to Immunization History.

Notes

Add notes on multiple levels throughout all patient contact screens. Notes can contain multiple images, drawings, and images selected from a library. You can create voice recordings, and use auto-expand text. The Note dialog box contains up to four tabs: *Text, Image, Voice,* and *Import*, depending upon the location of the note in HealthMatics EMR.

Using text in notes



Icons - Enter and manipulate text using the *Text* toolbar icons:

Icon	Name	Action
	Load	Uploads plain text from a file
	Save	Saves text to a file
	Cut	Cuts text from the note
	Copy	Copies text from the note
	Paste	Pastes copied or cut text to a note
	Undo	Undoes the last action
	Clear	Clears the message text
	Spell Check	Runs spell checker
	Spell Check Options	Edits spell checker options
	Auto Replace Options	Adds, edits, deletes, or copies auto-replace text

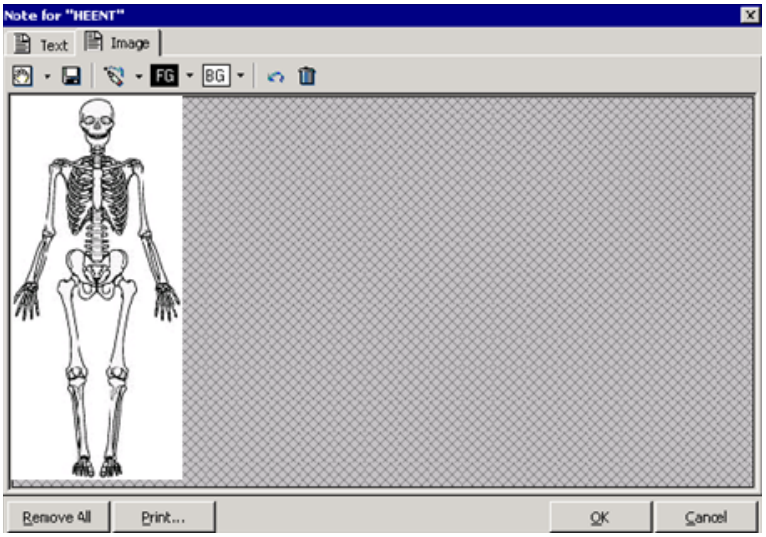
Remove all - Click to remove all data entered on the *Text* tab.

Print - Click to print text data.

Using images in notes

You can enter multiple images into a note. From a Note dialog, click the **Image** tab to enter, view, or edit image data.

NOTE: Due to file size, two images maximum per note is recommended.



Icons - Manipulate the image using the *Image* toolbar icons.

icon	Name	Action
	Load	Loads image from a file, from the anatomical picture library, or from the photo import dialog. Click the icon to open a browse window. Click the arrow to select the source for the image: • **File System** • **Library** • **Import Photo**
	Save	Saves image to file
	Drawing tools	Click arrow to select a drawing tool: • **Pencil** - Draw a free form line • **Line** - Draw a straight line • **Rectangle** - Draw an empty rectangle • **Filled rectangle** - Draw a filled rectangle • **Circle** - Draw an empty circle • **Filled circle** - Draw a filled circle • **Text** - Enter text (Enter text in the text box, click **OK**, then click the image where you want to insert the text.)
	Foreground color selector	Clicks arrow to display color pallet for foreground
	Background color selector	Click arrow to display color pallet for background
	Undo	Undoes the last change
	Clear	Clears note

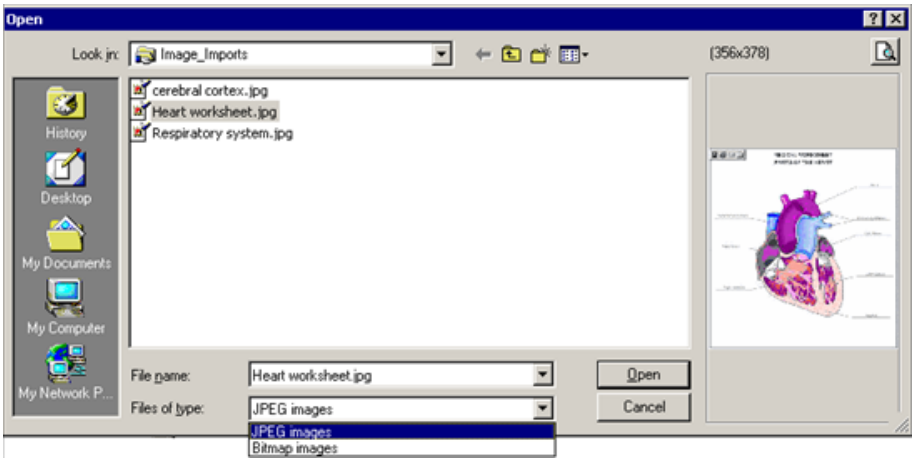
Remove all - Click to remove all data entered on the *Image* tab.

Print - Click to print the image data.

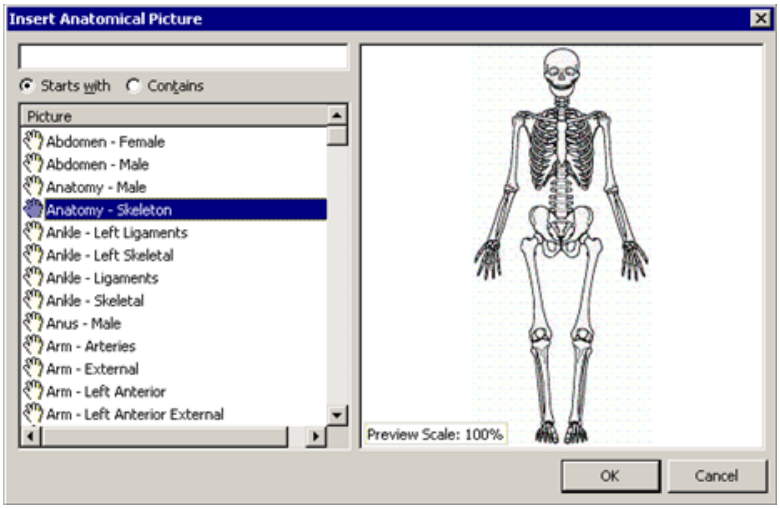
To add images to notes

1. In any HealthMatics EMR Note dialog box, click the **Image** tab.
2. Click (Load) **down-arrow** to display a menu of sources for the image.
3. Select **one** of the following sources and then follow the appropriate instructions:

- **File system** - Browse to locate the appropriate image on your computer or network. JPEG (.jpg) and Bitmap (.bmp) images are supported.

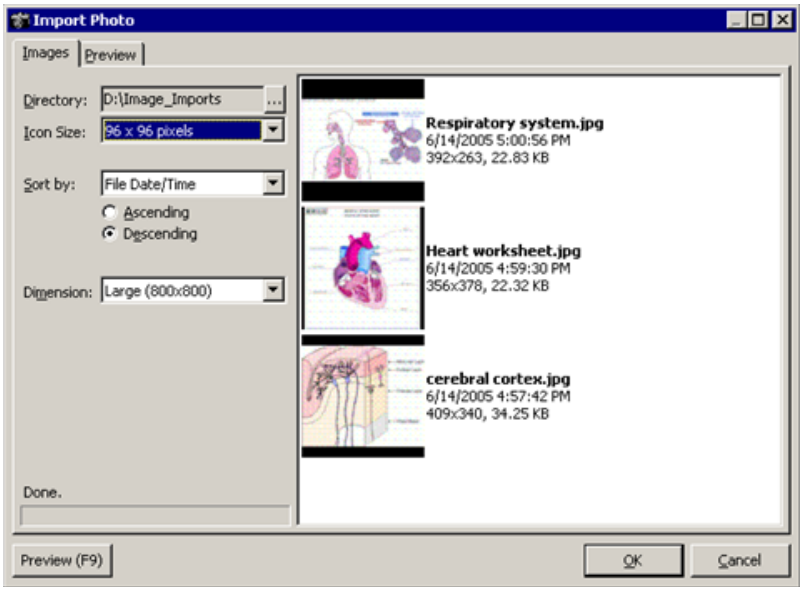


- **Library** - Scroll to locate or search for the appropriate image in the *Anatomical Pictures* library contained within HealthMatics EMR.



NOTE: Custom pictures can be added to the library using HealthMatics EMR Clinical Customization Module (see the HealthMatics EMR ***Clinical Customization*** manual).

- **Import photo** - At *Directory*, click the search button to browse to the directory containing the photos.



NOTE: Import Photo remembers all settings for each caregiver. It scans for bitmap and jpeg format files in the selected directory.

> **Locate the image you need:**

  – **Directory** - Search for the directory holding jpeg and bitmap images.

  – **Icon size** - Set size in pixels to display “thumbnails” in the list.

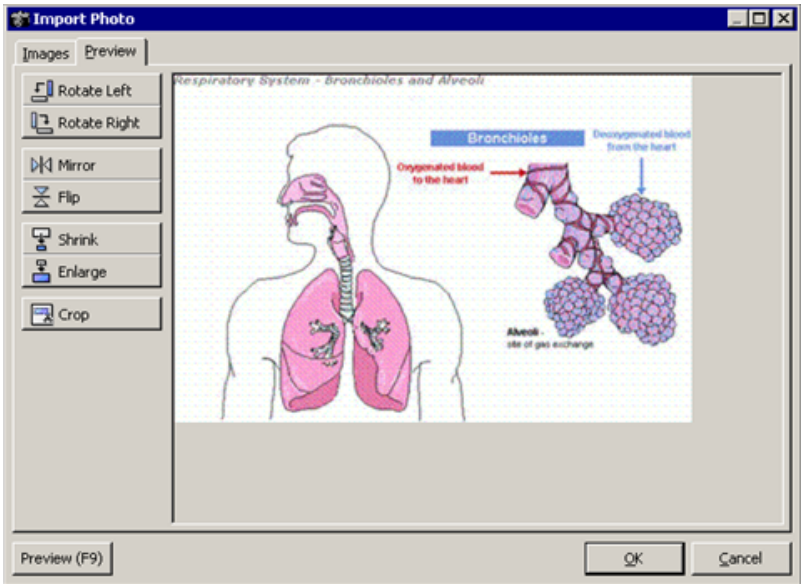
  – **Sort by** - Sort files in directory by *Date, Name, Type*, or *Size*. Files are scanned in this order.

  – **Order** - Select ascending or descending order to list files. Files list in descending date order by default.

  – **Dimension** - Set maximum size of the image after import or for preview. The original image is scaled proportionally to fit the selection.

> **Edit the image**.

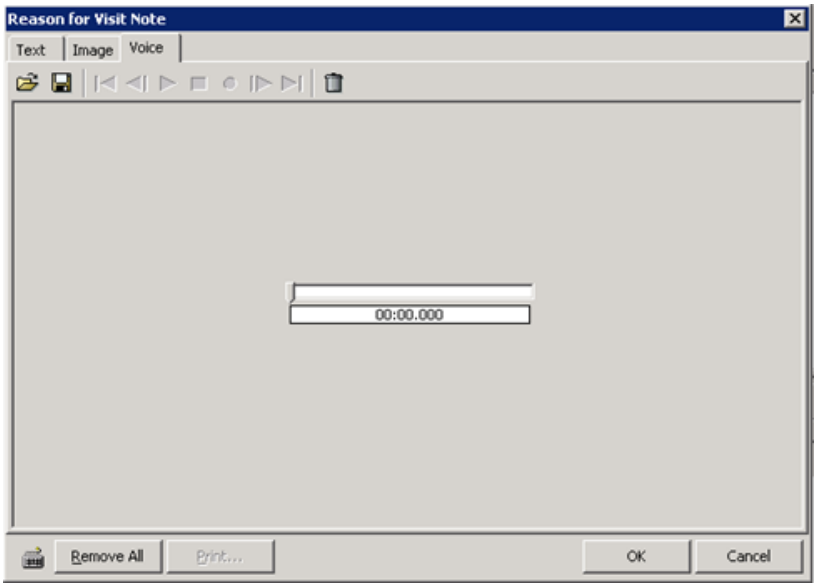
– Click the **Preview** tab at the top of screen ***or*** the **Preview** button at the bottom of the screen to preview and edit the image.



– **Manipulate** - Rotate, mirror, flip, resize, or crop image as needed. Changes are applied to the imported photo.

Entering voice messages in notes

Throughout the patient contact screens in HealthMatics EMR, you can enter voice notes up to 5 minutes in length by clicking any **Note** button and then selecting the **Voice** tab to display the voice recorder.



The field displays the recording time elapsed, once you click the record button. In addition, a moving black bar proceeds across the field to the end as the allowed 5 minutes lapses.

NOTE: In order to use the *Voice* tab, the application must be running on a full client and your workstation must have a sound card.

1. With a patient chart open in HealthMatics EMR, locate a Note with a voice tab.

Icon	Contact Screen	Action
	Reason for Visit	Click on the toolbar in the middle of the screen, then click the **Voice** tab.
	Review of Systems	For a general note, in the right pane next to *Review of Systems*, click , then click the **Voice** tab.
	History	Click **Note** near the top of the screen, then click the **Voice** tab.
	Vitals	Click **Note** near the top of the screen and then click the **Voice** tab.
	Physical Exam	For a general note, click after *Physical Exam* in the right pane and then click the **Voice** tab.
	Assessment/Plan	Click **Note** near the middle of the screen and then click the **Voice** tab.

Record using the following recording buttons.

Button	Action
	Go to the beginning of the recording
	Rewind
	Play
	Stop
	Record
	Fast Forward
	Fast forward to the end of the recording

2. Click (Record) and begin speaking into your computer's microphone.

NOTES
* When you first enter the *Voice* tab to record a new note, only the red record button is enabled. All other buttons are grayed out.

* As soon as you click Record, the black field displays lapsed recording time and all buttons other than the stop button are grayed out.

3. When finished, click (Stop) to stop recording the voice or sound and enable all the other buttons.
4. Click (Play) to play back the recording.

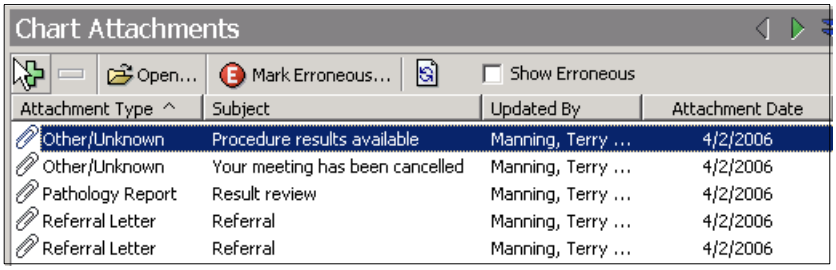
5. Click (Stop), (Rewind), and (Fast Forward), as needed.
6. Click (Erase) to delete the entire voice note.
7. Click (Reset) to reset the recording to the original file.
8. Click **Remove All** at the bottom of the screen to delete data from all tabs.
9. To save the recording, click **OK** at the bottom of the screen.
   The recording is stored for transcription.

NOTES

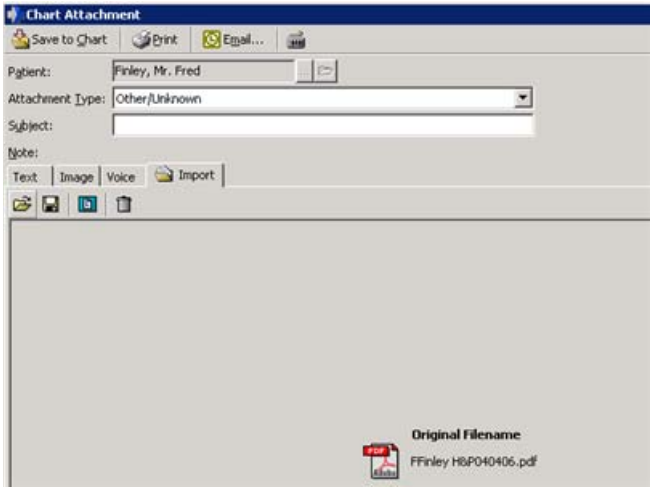
- A blue page with a turned down corner on a tab Voice indicates information exists on that tab.
- All notes can be reviewed on the H&P Report screen.

Importing files as chart attachments

1. With a patient chart open, from the HealthMatics EMR toolbar, click **> Chart Attachments**.



2. Press **Insert** on your keyboard ***or*** click (Add Attachment).
3. Click the **Import** tab.



NOTE: The Import tab displays only on the Chart Attachment screen.

4. Click (Load from File), locate and select to the file and click **Open** to attach it to the chart

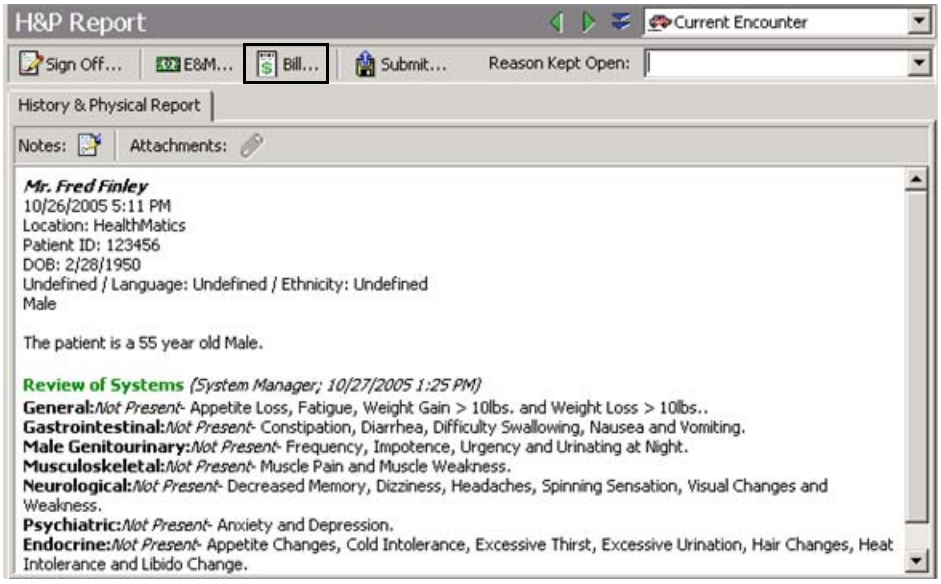
Icons - Load and save imported files to a patient chart using the *Import* toolbar icons.

Icon	Name	Action
	Load	Click to load from a file.
	Save	Click to save to a file.
	View	Click to launch a file in the associated viewer.
	Clear	Click to clear imported data.

H&P Report

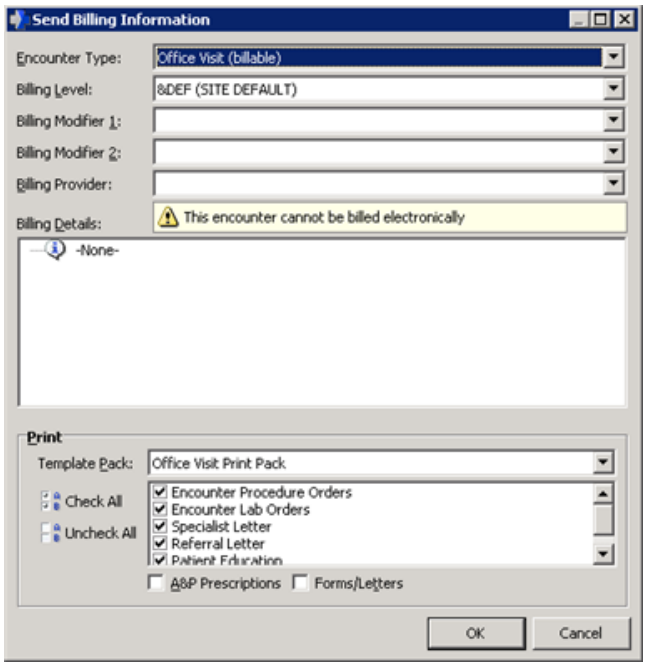
You can view the H&P Report at any time while documenting an encounter. This report contains all the information entered in each of the contact screens (Reason for Visit, Review of Systems, History, Vital Signs, Physical Exam, and Assessment/Plan).

Open a patient chart, and from the left pane ***or*** the toolbar, click (H&P Report).


H&P Report
Current Encounter
Sign Off...
E&M...
Bill...
Submit...
Reason Kept Open:
History & Physical Report
Notes:
Attachments:
Mr. Fred Finley
10/26/2005 5:11 PM
Location: HealthMatics
Patient ID: 123456
DOB: 2/28/1950
Undefined / Language: Undefined / Ethnicity: Undefined
Male
The patient is a 55 year old Male.
Review of Systems (System Manager; 10/27/2005 1:25 PM)
General:Not Present- Appetite Loss, Fatigue, Weight Gain > 10lbs. and Weight Loss > 10lbs..
Gastrointestinal:Not Present- Constipation, Diarrhea, Difficulty Swallowing, Nausea and Vomiting.
Male Genitourinary:Not Present- Frequency, Impotence, Urgency and Urinating at Night.
Musculoskeletal:Not Present- Muscle Pain and Muscle Weakness.
Neurological:Not Present- Decreased Memory, Dizziness, Headaches, Spinning Sensation, Visual Changes and Weakness.
Psychiatric:Not Present- Anxiety and Depression.
Endocrine:Not Present- Appetite Changes, Cold Intolerance, Excessive Thirst, Excessive Urination, Hair Changes, Heat Intolerance and Libido Change.

Viewing billing information

1. To view billing information based on the items documented, click Bill... or **Sign Off**.



Field	Action
Encounter type	Click down-arrow to select appropriate encounter type and billing status (billable or non-billable.
Billing level	Click down-arrow to select CPT code for the service level provided. **NOTE:** Billing level passes from the E&M Calculator if used.
Billing modifier	Click down-arrow to select appropriate modifier(s) if you need to link billing modifiers.
Billing provider	If needed, click down-arrow to select appropriate billing provider. **NOTE:** The default billing provider is the caregiver of record.
Billing details	Click labs/procedures to select/deselect for billing. **NOTE:** *Billable items* display in bold, preceded by green dollar bill. *Non-billable* items are preceded by gray dollar bills. Labs/procedures **not** in bold are **not** sent to your PMS for billing.

Indicating reason charts are kept open

If you are unable to complete and sign off on a chart immediately at the end of the encounter, indicate the reason for keeping the chart pulled on the H&P Report.

1. Open a patient chart, and from the toolbar, click (History & Physical Report).
2. At *Reason Kept Open*, enter the reason for keeping the chart pulled ***or*** click down-arrow and select a reason from the list.

NOTE: To review a list of open encounters, click (Open Encounters) on your status bar or click Audit Open Encounters on the left navigation pane to review all open encounters by Caregiver, Location or Patient.

Editing current H&P reports

You can make changes to H&P reports, notes, and attachments for open encounters. Once the H&P Report is signed off, you can only indicate changes to the information it contains by creating an addendum (see To change encounter information or create addenda on page 156).

To edit current H&P reports

To edit the H&P Report for the current encounter, change information on the respective contact screens.

1. Open a patient chart, and from the left pane ***or*** toolbar, click the appropriate icon to return to the contact window that contains the data to change (Reason for Visit, Review of Systems, History, Vital Signs, Physical Exam, and/or Assessment/ Plan).
2. Change data as needed.

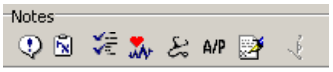
   NOTES
   * As data on the contact screens change, text in the H&P Report changes as does the name of the caregiver, date and time stamp.

   * Changes to the report that are saved as Notes (free-text entries) cannot be sent to your Practice Management System for electronic billing and must be billed manually.
3. Click (History & Physical Report) to view changes.

To change or review notes in current H&P reports

1. Open a patient chart, and from the left pane ***or*** toolbar, click (H&P Report).

   NOTE: *Notes* icons at the upper left corner of the H&P Report ( ) window are enabled when notes have been created in the corresponding section of the current encounter at the highest level. Click the icons to view or modify current encounter notes at the Visit, ROS, History, Vitals, PE, or Assessment/Plan level.

   Notes entered at lower levels are embedded in the H&P Report. Make changes to them in the associated contact screen.

2. Click the appropriate *Notes* icon.
3. View, change or insert text, image, or voice note.
4. Click **Print** and **OK** to print the note if needed.

   NOTE: Click **Remove All** to delete entire note.

5. Click **OK** to return to H&P.

To view attachments from H&P report

You can view attachments directly from the H&P window if any are attached to the encounter. Attachments include items such as forms and letters.

1. Open a patient chart.
2. From HealthMatics EMR toolbar, click the (Demographics) down-arrow, then click (Chart Attachments).
   - **IF** no attachments are linked with the encounter, the information icon with **None** displays in the *Chart Attachments* window.
   - **IF** attachments are linked, the *Chart Attachments* window displays the attachments linked to the current encounter.
3. To view the attachment(s), double-click it or select it and click (Open) to view.
4. You can **Email**, **Print** the attachment(s), or Save Attachment to Chart. Click **x** in right upper corner to return to H&P Report.

Finalizing encounters from H&P

At the end of a patient encounter, there are several options available from the H&P Report:

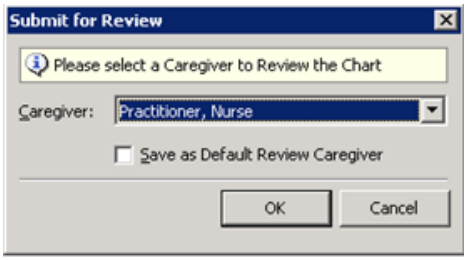
- **Sign off** - Sign off and file the chart, locking all documentation for the encounter. Printing choices are available from the Sign Off window.
- **E&M calculator** - Classify diagnoses, enter medical decision-making and verify the billing level.
- **Bill** - Bill the encounter (with or without signing off the chart). Printing choices are available from the Sign Off window.

- **Submit** - Send the chart for review by another caregiver.

To conduct chart reviews

The chart review functionality is designed for use with residents, physician assistants, and nurse practitioners, who must have attending physicians review and sign off on their work.

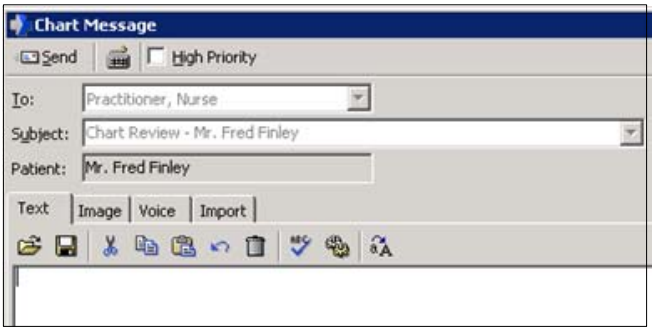
1. With a patient chart open in HealthMatics EMR and the encounter documentation complete, from the left pane ***or*** the toolbar, click (H&P Report).
2. Click Submit... to display Submit for Review.



3. At *Caregiver*, click down-arrow and select a reviewing caregiver from the list.

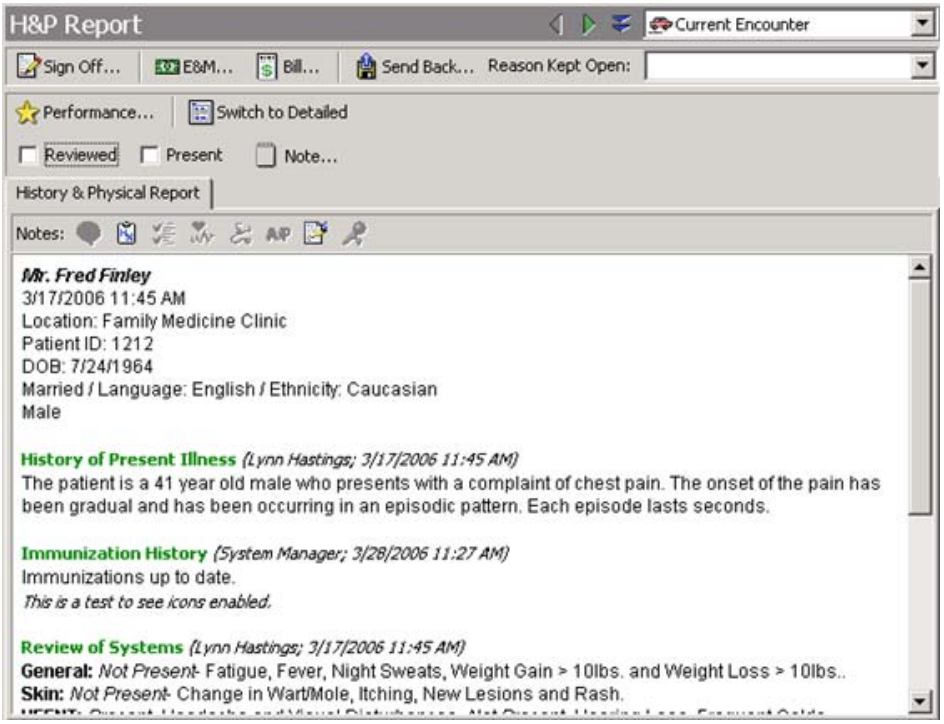
   NOTE: To make a caregiver the default reviewer for the caregiver logged in, select the **Save as Default Review Caregiver** checkbox, then click **OK**.

4. The *To* and *Subject* fields of the chart message fill automatically.



5. If required, click to select the *High Priority* chart review checkbox.
6. If desired, include a *Text* (or other) note.
7. Click (Send).
   The application sends a message to the reviewer's inbox under *Received Charts* with the subject, *Chart Review* or *Review Received Charts* from the status bar.
8. Access received charts as described in Received Charts on page 80.
9. Double-click the *Chart Review* item to display the message.

10. Click **Pull Chart** then **Yes** to delete the transmittal chart message and open the patient chart.


H&P Report
Current Encounter
Sign Off...
E&M...
Bill...
Send Back...
Reason Kept Open:
Performance...
Switch to Detailed
Reviewed
Present
Note...
History & Physical Report
Notes:
Mr. Fred Finley
3/17/2006 11:45 AM
Location: Family Medicine Clinic
Patient ID: 1212
DOB: 7/24/1964
Married / Language: English / Ethnicity: Caucasian
Male
History of Present Illness (Lynn Hastings; 3/17/2006 11:45 AM)
The patient is a 41 year old male who presents with a complaint of chest pain. The onset of the pain has been gradual and has been occurring in an episodic pattern. Each episode lasts seconds.
Immunization History (System Manager; 3/28/2006 11:27 AM)
Immunizations up to date.
This is a test to see icons enabled.
Review of Systems (Lynn Hastings; 3/17/2006 11:45 AM)
General: Not Present- Fatigue, Fever, Night Sweats, Weight Gain > 10lbs. and Weight Loss > 10lbs..
Skin: Not Present- Change in Wart/Mole, Itching, New Lesions and Rash.

You can conduct an *Overall* or *Detailed* (section by section) chart review.

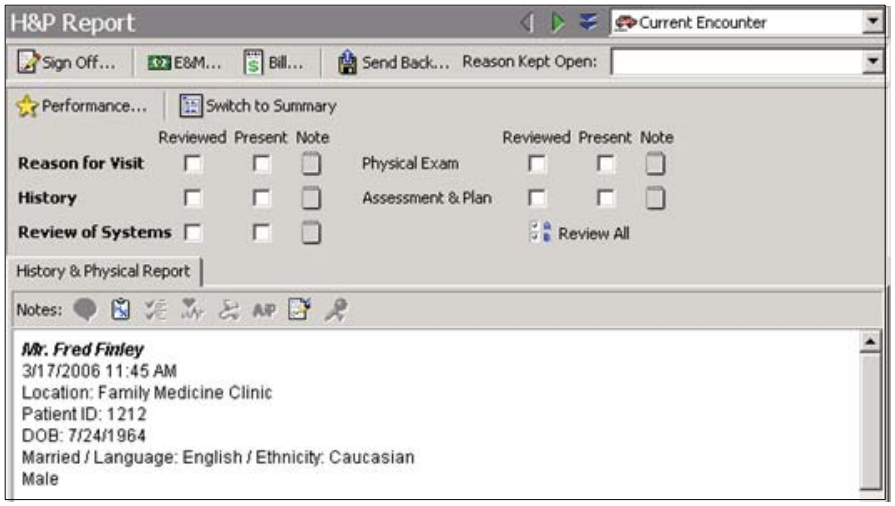
Overall chart reviews

At *Overall Chart Review*, check the appropriate box(es):

- **Reviewed** - Check this box to indicate you reviewed the chart.
- **Present** - Check this box to indicate you were present during the encounter.
- **Note** - Check this box to enter a *Chart Review Note for History and Physical.*

Detailed chart reviews

1. Click Switch to Detailed to go to a detailed chart review by section.



2. To document your review of the chart, do **one** of the following:

   - **Review sections individually** - For each of the five sections of the chart, click the appropriate checkbox to indicate whether you *Reviewed* or were *Present* for that part of the encounter, or both.

     Click the **Note** box to include a note for that part of the encounter and enter a note using any of the tabs available, then click **OK** to return to the H&P Report review screen. A check mark displays in the *Note* box on the H&P Report screen.

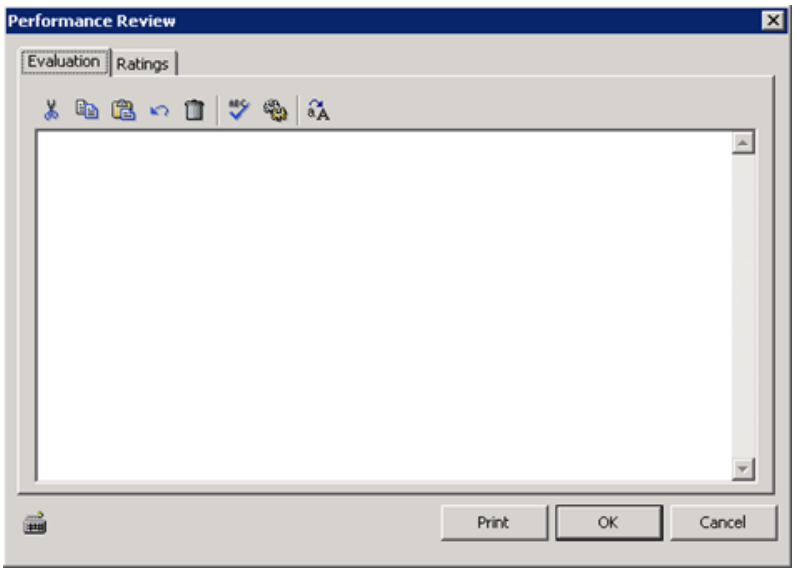
   - **Review all** - Select the **Review All** box if you want to indicate with one click that you reviewed all sections of the H&P Report.

     NOTE: All chart sections that contain information (which are bolded and preceded by check marks) are marked *Reviewed*. You can still check individual *Note* boxes and add notes as appropriate.

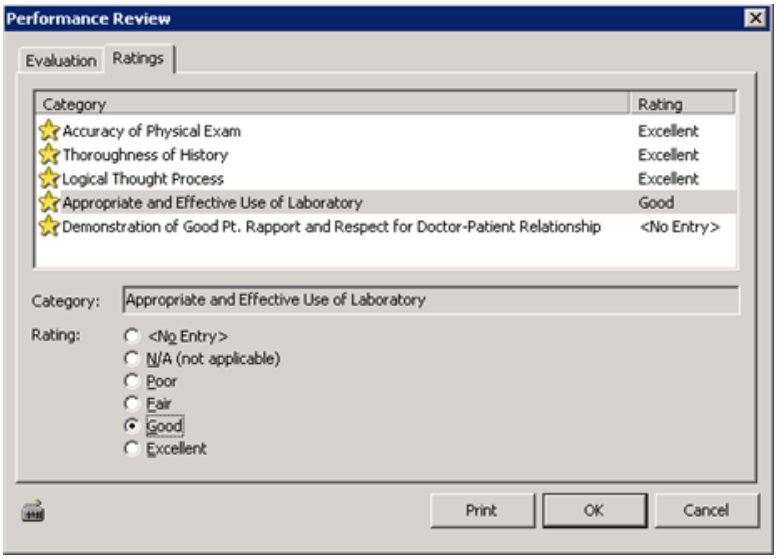
3. Click Switch to Summary to return to H&P.

To conduct performance reviews

1. To access the chart review window, see To conduct chart reviews on page 357.
2. From the chart review H&P Report, click Performance.



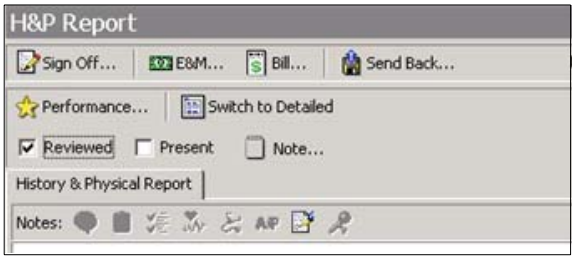
3. Rate the caregiver performance.
   - Use the Evaluation tab to add performance review comments if desired.
   - Use the *Ratings* tab, to indicate performance in each selected area.

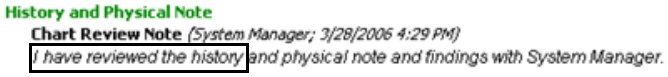


4. Click **Print** to display Print Preview.
   - Use the preview buttons as needed and then click to print review.
   - Click **Close** to return to Performance Review.

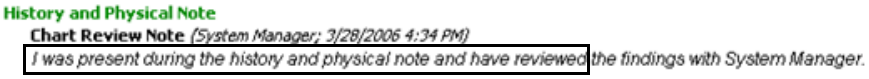
   NOTE: You must print the Performance Review to have a record of it. The Review is not saved in the EMR.

5. Click **OK** to return to the H&P Report.
6. In *Overall Chart Review*, select the **Reviewed** checkbox to add an automatic annotation. Add a **Note**, if desired.




History and Physical Note
Chart Review Note (System Manager; 3/28/2006 4:29 PM)
I have reviewed the history and physical note and findings with System Manager.

You can select both the *Present* and *Reviewed* checkboxes to add an automatic annotation that the reviewer was present during the review described.


History and Physical Note
Chart Review Note (System Manager; 3/28/2006 4:34 PM)
I was present during the history and physical note and have reviewed the findings with System Manager.

7. To finalize the encounter do one of the following:
   - To send the chart back to the original caregiver for sign off, click **Send Back.** Enter message information as needed and click **Send**.
   - **To print** documents for the patient without signing off the chart, see To print patient information documents without signing off on chart on page 361.
   - **To bill** the encounter without signing off the chart, click **Bill**. (See To send encounter billing information without signing off on page 363).
   - **To sign off**, bill the encounter, and refile the chart, click **Sign Off.** (See Signing off charts on page 364 for detailed instructions.)

NOTES

- The performance review will not display after signing off on the chart.
- Once the encounter is signed off, you cannot retrieve the performance review.

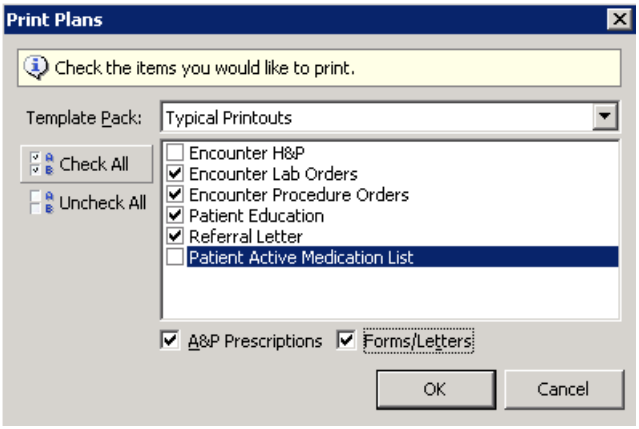
To print patient information documents without signing off on chart

Within HealthMatics EMR, if you complete patient contact, but not the encounter documentation, you can print items the patient may need as they leave your office without signing off on the chart.

To use this function fully, be certain to complete the Assessment/Plan, so all prescriptions, referrals, orders and forms/letters are available for printing.

1. With the patient chart open in HealthMatics EMR, from the left pane ***or*** the toolbar, click (H&P Report).

2. From the HealthMatics EMR toolbar, click the > **Draft**.



Field/Checkbox	Action
Template pack	Click down-arrow to make different selection if desired. **NOTE:** Choices include fax print packs as well as non-print options. Template Packs are created in the Administration Module.
Check all	Click to choose all options.
Uncheck all	Click to deselect all options.

3. From the Print Plans window, select print items and click **OK**.
   Each item displays individually.
   - To use biometric authentication, leave the password on the screen blank.
     > **IF** the password is blank and the Biometric Authentication hardware and software are installed and the system administrator has enabled Biometric Authentication system options, you will receive a prompt for a fingerprint.
     > **IF** any of the above conditions are not met, “Enter a valid password” displays.
     > **IF** a password is entered and the application is set to require biometric authentication, the application ignores the password and prompts for a fingerprint.
   - For *Referrals*, click H&P Sections to select the sections of the H&P you want to include in the referral letter.
   - Continue completing information on the screens for each item you want to print.
4. Click **OK** to print all items and return to the H&P Report.

NOTES

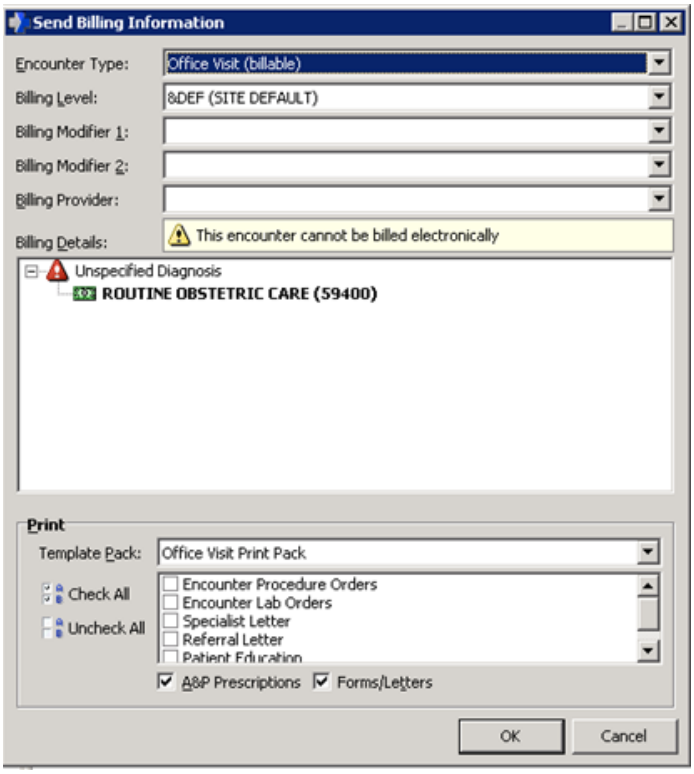
- When all items are printed or sent, you return to the H&P Report. Continue documenting and/or sign off on the encounter.

- Drafting does not bill the encounter or sign off the chart. Therefore, you can go back afterward and complete all other contact screens before going to the E&M Calculator and signing off on the chart.

To send encounter billing information without signing off

If you use a billing interface, you can send billing information to your Practice Management System (PMS) without signing off on the chart.

1. With a patient chart open in HealthMatics EMR, from the left pane ***or*** the toolbar, click (H&P Report).
2. From the H&P secondary toolbar, click Bill.



See Viewing billing information on page 354 for field explanation. See To print patient information documents without signing off on chart on page 361 for print choices if desired.

3. In *Billing Details*, click labs and procedures to select/deselect them for billing:
   - Billable items display in **bold,** preceded by green dollar signs $.
   - Non-billable items display in regular font preceded by gray dollar signs $. Labs/procedures **not** bolded are **not** sent to your PMS for billing.
4. Click **OK** to send the billing information to your PMS.

NOTE: You may see any of the following three messages on your *Send Billing Information* screen displayed under the *Billing Provider:*

- **This encounter cannot be billed electronically** - The encounter billing information must be manually entered into your PMS. Only encounters associated

with a scheduled appointment can be sent across the billing interface. If this message displays, the patient chart was probably not pulled from the appropriate place, and therefore not linked to an appointment. For electronic billing, always pull charts from one of the following:

> From the Appointments view ***or***

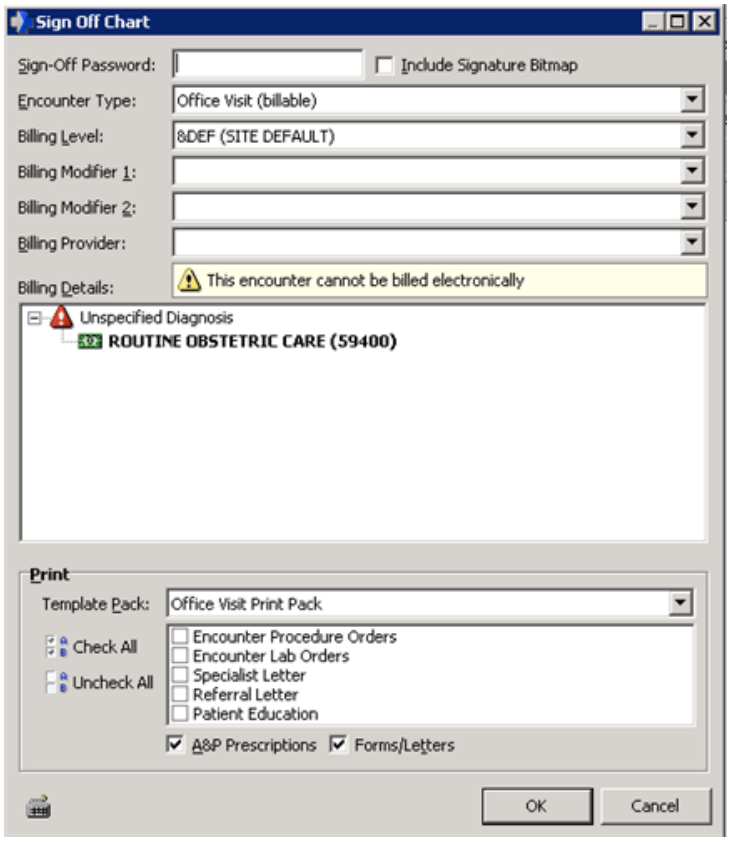
> If the chart was sent to you by another caregiver during an encounter, from the Received Pulled Charts icon on your status bar.

- **Don't forget to select a billing provider** - This message displays when the encounter is associated with an appointment, but the caregiver with whom the appointment is scheduled does not have billing responsibilities. In that case, the *Billing Provider* must be manually selected from the selection list.
- **Billing has already been sent** - This message displays if the billing information was sent using the **Bill** button.

Signing off charts

Encounter information can be modified at any time until the chart is signed off. However, once you sign off on the chart, you can only modify it by creating addendum notes (see To change encounter information or create addenda on page 156).

1. With a patient chart open in HealthMatics EMR, and the encounter completed, from the left pane ***or*** the toolbar, click (H&P Report).
2. From the H&P secondary toolbar, click Sign Off.



3. At *Sign-Off Password*, enter your password.

   NOTE: If the application is set to require biometric authentication, it ignores the password and prompts for a fingerprint.

4. Select **Include Signature Bitmap** if you have a signature bitmap on file and want to use it.

   NOTE: The rest of this dialog box is the same as the Send Billing Information dialog box (see Viewing billing information on page 354).

5. In the *Billing Details* pane, select (or deselect) each item that should be sent to the Practice Management System for billing.

   NOTE: Selected (billable) items display bolded, preceded by a green **$** sign.

6. Click **OK**.

7. Type your sign-off password again, if necessary, to electronically sign any prescriptions written.

   NOTE: If an electronic signature was entered into the HealthMatics EMR database, you can sign lab orders electronically. If a digital signature was not placed in the database, the *Add Signature* check box does not display.

The chart is automatically filed and the encounter becomes a part of the patient permanent record.

NOTE: At signoff, the application checks to see if a managed item was modified in History, but not in Assessment/Plan. If so, it edits the Assessment/Plan item to match the values of the History entry. However, medications entered into History but not ordered in Assessment/Plan are recorded as Active, so that they do not appear as prescribed by the caregiver.

Evaluation & Management Calculator

The application automatically calculates billing levels based on information entered in patient contact screens. The Evaluation & Management (E&M) calculator serves all nine specialty areas (Cardiovascular, ENT, Genitourinary, Hematologic/Lymphatic/Immunologic, Musculoskeletal, Neurologic, Psychiatric, Respiratory, Skin) and uses Alpha II/Unicore Med technology to analyze the procedures documented and suggest an E&M level for an encounter. All exam types are available to caregivers and all possible exam systems, body parts, and organ parts are within the database.

The E&M overall calculation is based on 1997 E&M Documentation Guidelines that map HealthMatics EMR clinical terms to codes provided by Spring Management. After the mapping takes place, the application feeds the codes to a dynamic library file where the codes are summarized to generate a score. Visit the Spring Management website, www.springmgmt.com to request backup data for the E&M calculator.

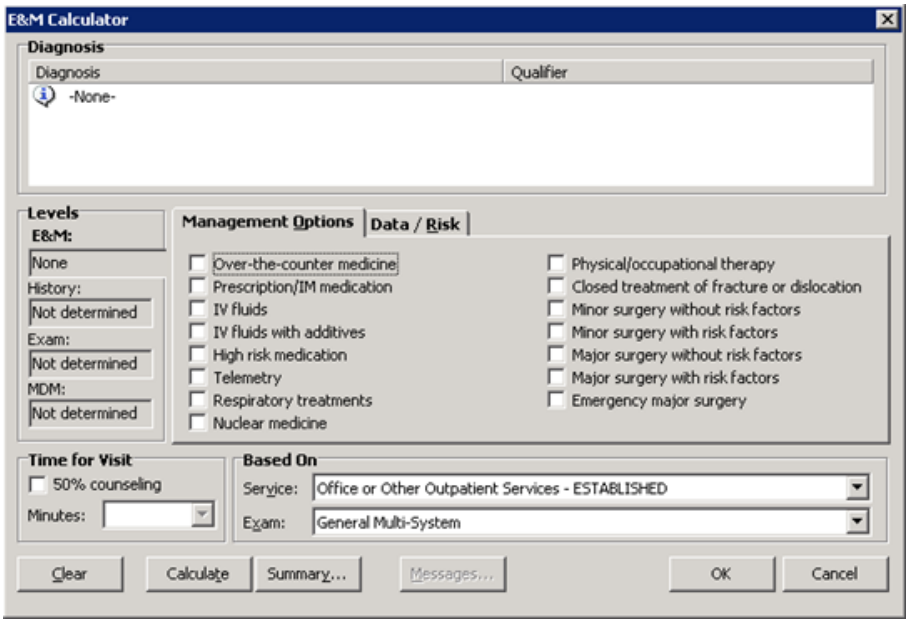
NOTES

For the exams to calculate accurately, be certain to always install Quarterly EK Quips as soon as you receive them. The EK Quips are necessary to enable and update existing physical exam templates in Knowledge Manager with the latest Physical Exam terms.

View archived items to make certain the knowledge you want to use is enabled.

Accessing E&M calculator

With a patient chart open, click (H&P Report), then click (E&M Calculator).c



Field/checkbox Section	Action
Diagnosis	
	Defaults from H&P Report
Qualifier	Click the down-arrow to the right to choose one of six diagnosis qualifiers.
Levels	
E&M	Displays the Evaluation & Management level that results when you click **Calculate**, based on data documented and the items selected in the calculator.
History	*Problem focused, Detailed, Comprehensive* **NOTE:** History characteristics are mapped to HPI elements used in the calculation. Reason for Visit, ROS and Past Family and Social History.
Exam	Based on documentation in Vitals and Physical Exam
MDM	Medical Decision Making - Based on diagnosis (or Management Options), the data reviewed, and the risk associated with presenting problems. *Straight forward, Low, Moderate,* or *High*. This shows in the H&P Report.
Management Options	

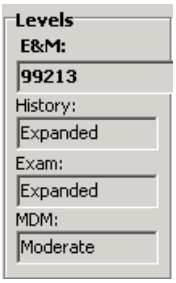
Field/checkbox Section	Action
	Click to select items used to determine risk levels for the encounter. Risk is based on a combination of your diagnosis codes and management options.
Data/Risk	
Lab test(s)	Populate directly from A/P screen.
Independent visualization of lab test	
CPT medicine test(s)	Refers to any diagnostic test in the 90000 range. Populates when ordered in A/P.
Independent visualization of CPT medicine test	
Radiology test(s)	Populates when ordered in A/P.
Independent visualization of radiology test	
Decision to obtain old records	Self-explanatory
Decision to obtain information from someone other than patient	Self-explanatory
Summary of old records	Self-explanatory
Discussion with another health care provider	Self-explanatory
discussion with MD performing test(s)	Self-explanatory
Based On	
Service	Click down-arrow to select a service level. **NOTE:** Defaults for the Service level can be set at the caregiver level in **Options > Edit Options > Sign Off**.
Exam	Click down-arrow to select an exam type. **NOTE:** Defaults for the Exam type can be set at the caregiver level in **Options > Edit Options > Sign Off**.
Time for Visit	
50% counseling	Click checkbox to indicate over 50% of the visit was spent counseling and/or coordinating care.

Field/checkbox Section	Action
Minutes	Indicate the total duration of the visit.
Button Functions	
Clear	Resets all checkboxes.
Calculate	Generates the E&M visit level.
Summary	View details that produced the service visit level when calculated. (See Summarizing the service level on page 370.)
Messages	Additional information from *AlphaIIClaimmaker* to assist coding.

Understanding the E&M calculator

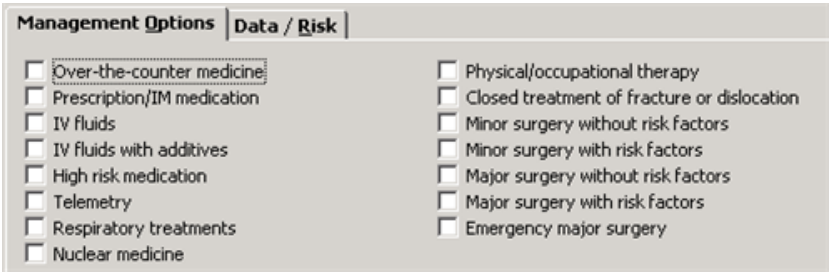
E&M level

Displays the Evaluation & Management level that results when you click **Calculate** and is based on the data documented and the items selected in the calculator.



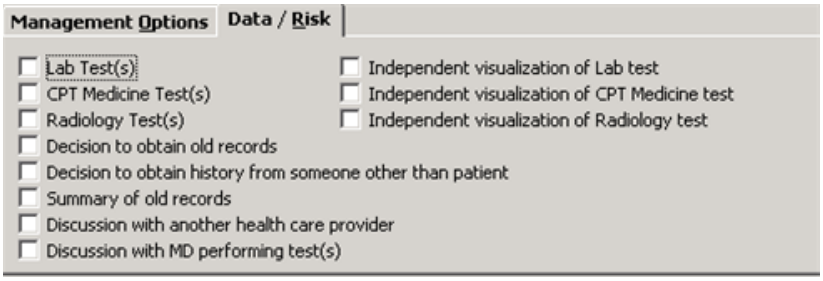
- **History** - The *E&M Level* of service is calculated from the documentation provided for History: *Problem-focused*, *Detailed*, and *Comprehensive*.
- **Exam** - The calculated levels of E&M services are also based on Vitals and Physical Exam documentation.
- **MDM** - (Medical Decision Making) - Displays in the H&P Report.

Management options.



Risk is based on a combination of diagnosis codes and your Management Options selection.

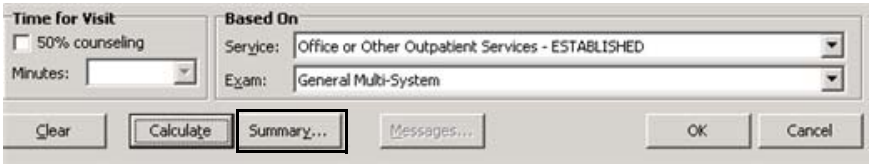
Data/risk


Management Options
Data / Risk
Lab Test(s)
CPT Medicine Test(s)
Radiology Test(s)
Decision to obtain old records
Decision to obtain history from someone other than patient
Summary of old records
Discussion with another health care provider
Discussion with MD performing test(s)
Independent visualization of Lab test
Independent visualization of CPT Medicine test
Independent visualization of Radiology test

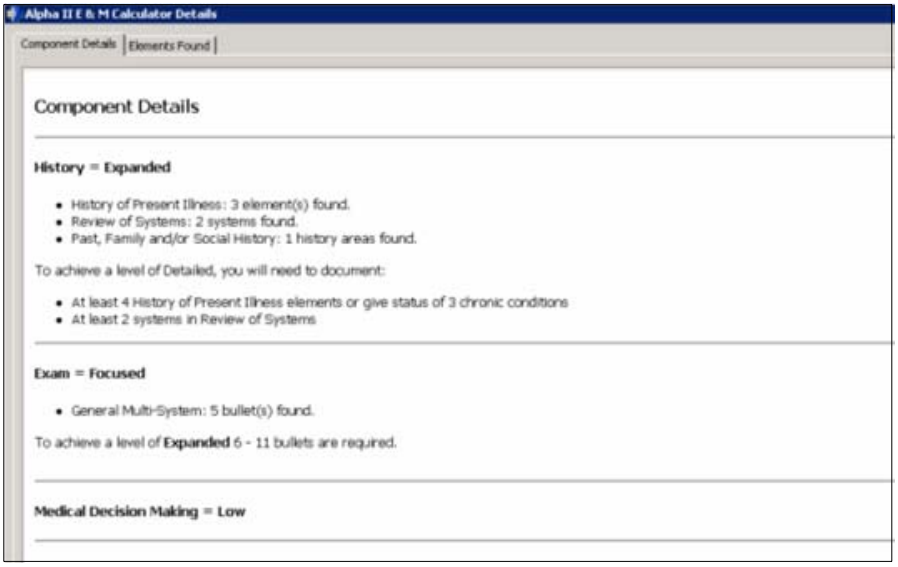
Checkbox Items in *Data/Risk* indicate the amount and complexity of the data reviewed during the encounter. Check any/all items that apply.

Summarizing the service level

A summary of service level credit received for the documentation is available.



1. From the bottom of the E&M window, click **Summary** to view details that produced the current service level.


Alpha II E & M Calculator Details
Component Details
Elements Found
Component Details
History = Expanded
History of Present Illness: 3 element(s) found.
Review of Systems: 2 systems found.
Past, Family and/or Social History: 1 history areas found.
To achieve a level of Detailed, you will need to document:
At least 4 History of Present Illness elements or give status of 3 chronic conditions
At least 2 systems in Review of Systems
Exam = Focused
General Multi-System: 5 bullet(s) found.
To achieve a level of Expanded 6 - 11 bullets are required.
Medical Decision Making = Low

2. Click the **Elements Found** tab to view a breakdown of the three coding levels with scores and how many other service levels are required to reach the next level.

Alpha II E & M Calculator Details
Component Details
Elements Found
Elements found
History = Expanded
History of Present Illness
Duration
Quality
Signs symptoms
Review of Systems
Constitution
GU
Past, Family and/or Social History
Medical History
Exam = Focused
Exam Type: General Multi-System
Cardiovascular / Abdominal aorta
Cardiovascular / Auscultation heart
Cardiovascular / Carotid arteries
Cardiovascular / Extremities for edema/varicosities
Cardiovascular / Femoral arteries
Cardiovascular / Palpation heart
Cardiovascular / Pedal pulses
Chest (Breast) / Inspection breasts
Chest (Breast) / Palpation breasts/axillae
Constitutional / Ability to communicate/quality of voice
Constitutional / General appearance
Constitutional / Measure three vital signs
Ear,Nose,Mouth and Throat / Ext auditory canals, tympanic membranes
Ear,Nose,Mouth and Throat / External inspection ears/nose
Ear,Nose,Mouth and Throat / Hearing (general)
Ear,Nose,Mouth and Throat / Lips,teeth,gums
Ear,Nose,Mouth and Throat / Nasal mucosa,septum,turbinates
Ear,Nose,Mouth and Throat / Oropharynx (general)
Musculoskeletal / RUE:Stability(dislocation,subluxation,laxity)
Musculoskeletal / Spine/Ribs/Pelvis:Inspection and/or palpation
Musculoskeletal / Spine/Ribs/Pelvis:Motion (pain,crepitation)
Musculoskeletal / Spine/Ribs/Pelvis:Muscle strength and tone
Musculoskeletal / Spine/Ribs/Pelvis:Stability (dislocation, subluxation, laxity)
Neck / Neck
Neck / Thyroid
Neurological/Psychiatric / Deep tendon reflexes
Neurological/Psychiatric / Sensation
Neurological/Psychiatric / Test cranial nerves
Psychiatric / Brief mental status:Mood and affect
Psychiatric / Brief mental status:Orientation time,place,person
Psychiatric / Brief mental status:Recent and remote memory
Psychiatric / Judgment, insight
Respiratory / Auscultation lungs
Respiratory / Palpation chest
Respiratory / Percussion chest
Respiratory / Respiratory effort
Skin / Inspection skin
Skin / Palpation skin
Shaded bullet = italic typeface; Unshaded bullet = regular typeface; Documented bullet = bold typeface
Overall Medical Decision Making Level = Low
Overall Medical Decision Making level is based on the highest two of these three elements.
Number of diagnoses or management options = Minimal/Straightforward (<= 1)
Amount and/or complexity of data to be reviewed = Limited/Low (2)
Independent visualization of Lab test - 2 point(s)
Risk of complications and/or morbidity or mortality(Moderate)
Prescription/IM medication - Moderate

Adjusting the service level

The *E&M Level* on the left side of the window displays the calculated level of service, based on data you entered for the encounter. You cannot change the information in the left pane directly. However, you can adjust the level of service.

1. Return to the contact screens (Reason for Visit, Review of Systems, and/or History (Family/Social) and continue documenting to accurately reflect the items discussed and evaluated during the patient visit.
2. Return to the E&M calculator and recalculate.

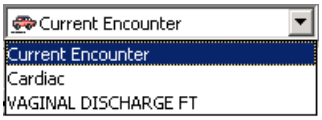
NOTE: For well visits and procedure-only visits, omit the use of the E&M Calculator.

Fast Track Templates

Fast Track templates can be created using a series of customized short lists to allow quick movement through all contact screens recommended for specific complaints. For instructions for building customized Fast Tracks, refer to the HealthMatics EMR ***Clinical Customization*** manual.

To document a patient visit using a customized Fast Track template, follow these steps:

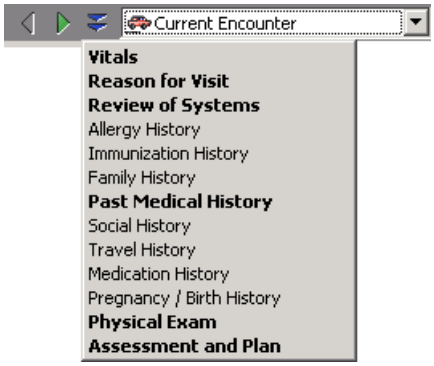
1. Open a patient chart and click the **Current Encounter** down-arrow to display a list of Fast Track templates.



2. Click the template name to automatically go to the first contact screen in the template.
3. Document patient information as you normally would in that screen, then from the Fast Track toolbar, click (Forward in Current Fast Track) to proceed to the next contact screen for the selected template.

NOTES

- To move to the previous contact screen for the template, click (Back in Current Fast Track).
- To see the systems and short lists included in the selected Fast Track, click (Show Details of Fast Track).



Cancel Contact

If you are documenting and do not want to save the information entered, (**Example:** you discover you are in the wrong patient chart), you can cancel contact with that chart.

1. With a patient chart open, from the HealthMatics EMR menu bar, click **Charts > Cancel Contact**.
2. In the Warning box, click **Yes**.

IMPORTANT!

Cancel Contact cancels changes you made (**along** with any other caregiver unless you used “Send Chart” between entries) during that contact only. If you enter data for the encounter, send the chart to another caregiver who returns it to you, and then you enter additional data, **Cancel Contact** only deletes items added in the second contact -- not the first.

If you made more than one contact with the patient chart and click **Cancel Contact**, verify that all pertinent data was cleared. If not, go to each contact screen and click **Clear**.

4. Printing and Faxing

All output functions are fully integrated into the Clinical Module, providing the ability to quickly generate documents that have been user-defined, location-defined, or site-defined from the point of care. You can queue, print, fax, save to log, export, and preview system-defined and customized documents without leaving the current screen in the **Clinical Module**.

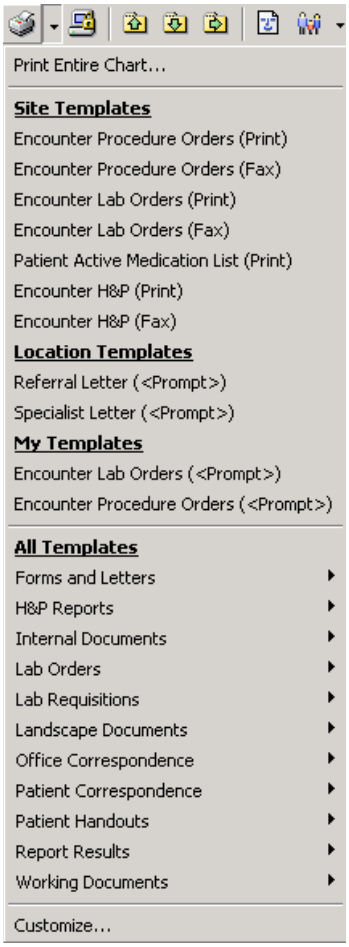
NOTE: *Output Queue* allows you to print later and still track the documents generated from within the EMR.

Print Terms

Term	Definition
Document	Template created in Output Manager
Template	Built in Output Manager by combining output blocks and assigning an Output Category • **Output blocks** - Text and data elements with their associated formatting that are used to build templates in Output Manager • **Data elements** - Similar to tokens in Forms and Letters. these data elements extract data from the EMR • **Layout** - The page setup for a template (margins, landscape vs. portrait page orientation) • **Output categories** - A filing system for templates. Printer and Layout defaults should be assigned to each category.
Output defaults	Screen within the **Administration Module** where printer and layout assignments are made **NOTE:** This screen is also available within the Clinical Module, but default assignments made here are only for the current user.
Output settings	Screens in the **Administration Module** where you define which documents display from the printer icon drop-down list by Site, Location, or Caregiver for each EMR screen, and where Encounter Packs are created.
Encounter pack	Group of documents that will generate at Signoff. These can be associated with, and then filtered by Encounter type.

Templates

From the toolbar in any view in the **Clinical Module**, clicking (Print) displays a list of all default templates selected for the view in the *Administration Module*.



Site Templates are templates made available as defaults to all locations within the practice.

Location Templates are templates specific to each location within the practice.

My Templates are additional templates defaults selected by the specific caregiver logged in.

:**All Templates** provide access to all templates available, listed by *Output Category.*

Click **Customize** to add more default templates to the view. They will display under *My Templates*.

NOTE: You can also select output templates for each view from the **Administration Module**.

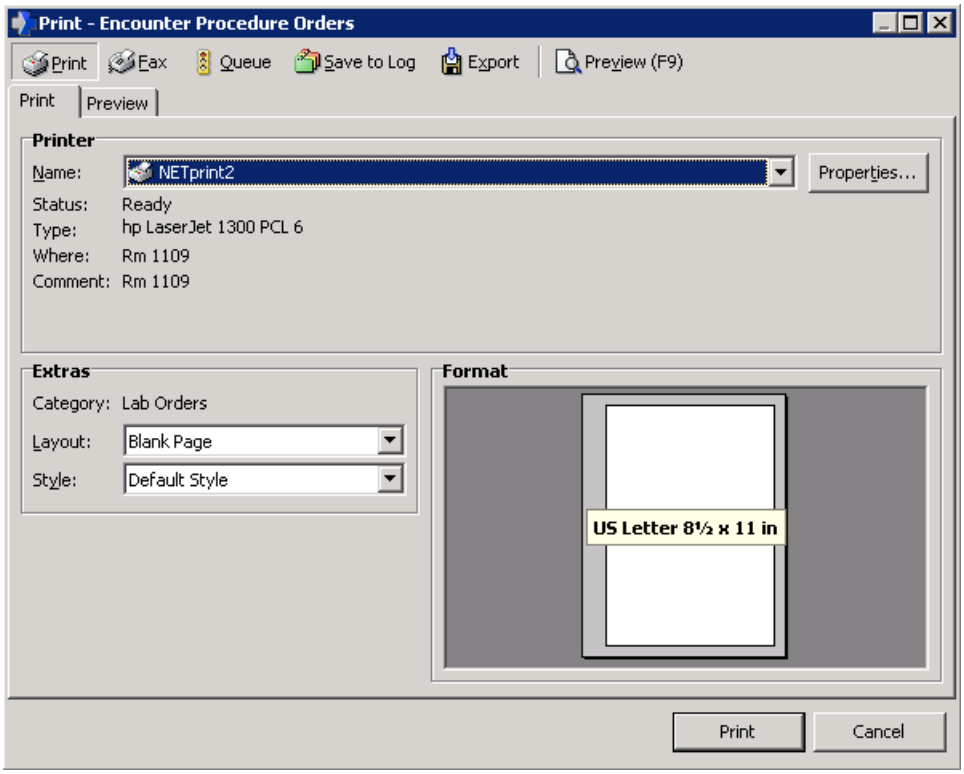
* **By caregiver** - Select **Caregiver >** select the caregiver **>** **> Output Defaults**
* **By location** - Select **Locations >** **> Output Defaults**
* **By site** - Select **Site Settings > Output Defaults**

Whenever possible, select Output Defaults at the **Site Settings** level.
For additional instructions, see Selecting output settings for each screen on page 386.

Printing from any view

1. On the toolbar, click (Print Information) and select the template you need for the document you want to generate.

   NOTE: If the template requires more information before it can print, a message tells you what additional information it needs (**Example:** Encounter, location, or date). Supply the information and click **OK** to display the Print screen.



   NOTE: If the template contains [*Dialog*] data elements, a pop-up window displays with tabs corresponding to each dialog data element. Choose the applicable information on each tab and click **OK** to continue to the Print screen.

2. In the *Printer* and *Extras* boxes, click down-arrows, if needed, to select the appropriate items.

3. **(Optional)** Click Preview to view the item before printing.

4. Click **Print**.

Print toolbar icons

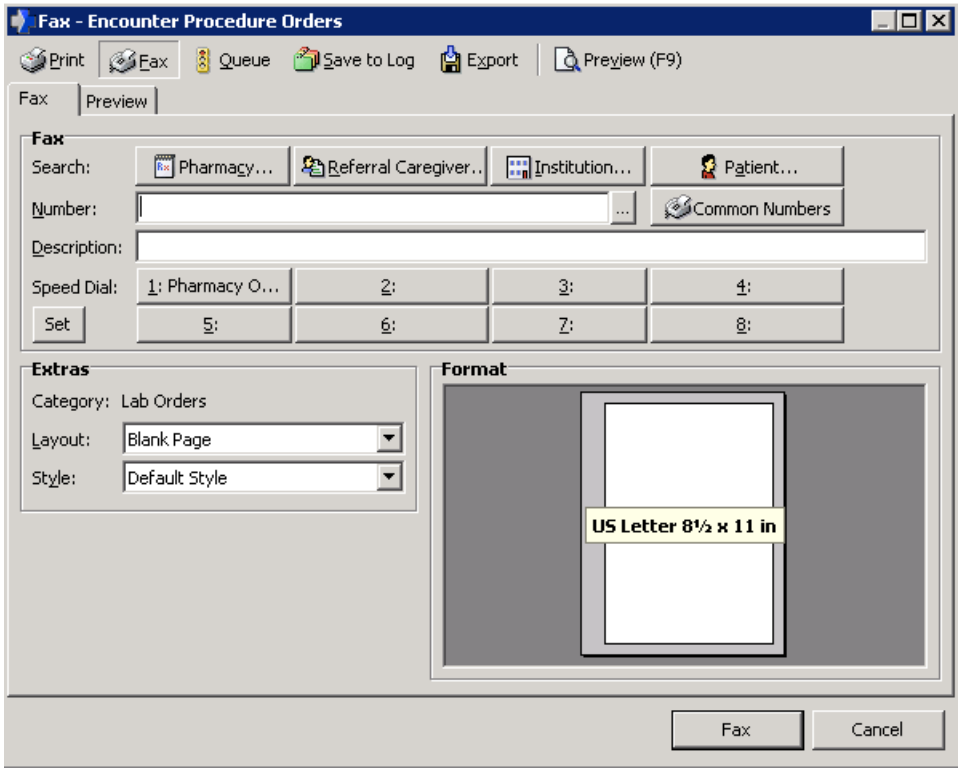
Use toolbar icons to do any of the following:

Icon	Name	Action
	Print	Print a document from the view. Click **Properties** to select *Layout* and *Paper/Quality*. **NOTE:** *Printer* and *Layout* defaults can be assigned in **Output Defaults**.
	Fax	Fax a document from the view.
	Queue	Send the document to the *Output Queue* for later printing. Enter a queue comment if desired
	Save to Log	Save the item in a log as output. Enter a log *Comment*, if desired.
	Export	Export the document to a file on your PC. Enter the *Filename*.
	Preview (**F9**)	Preview the document in the viewer (**Preview** tab).

Fill in information in the dialog that displays and click the appropriate button at the bottom of the screen to **Print, Fax, Queue, Save to Log, Export** or **Preview**.

Faxing from any view

1. On the toolbar, click (Print Information) and select the template you need for the document you want to generate.
2. Click the **Fax** tab.

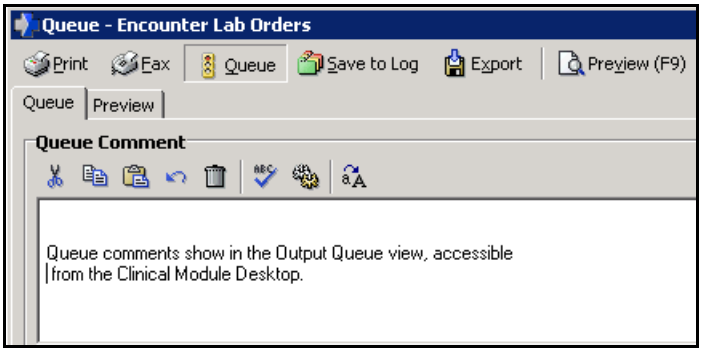


3. Locate the pharmacy number by doing any of the following:
   - **Search** - At *Search*, click any of the search buttons: **Pharmacy, Referral Caregiver, Institution**, or **Patient** to locate the fax number.
   - **Common numbers** - Click **Common Numbers** to display recently faxed numbers specific to the patient.
   - **Speed dial** - To save the fax number, once you locate it, click **Set** and then click a *Speed Dial* number (1 through 8). The pharmacy name displays on the selected button, and the Number and *Description* display in the appropriate fields.
4. **(Optional)** Click the **Preview** tab to preview the document.
5. To transmit the document, click **Fax**.

Queuing and saving to log from any view

NOTE: Only documents containing patient data can be queued or saved to log.

1. On the toolbar, click (Print Information) and select the template you need for the document you want to generate.
2. Click the **Queue** or **Save to Log** tab

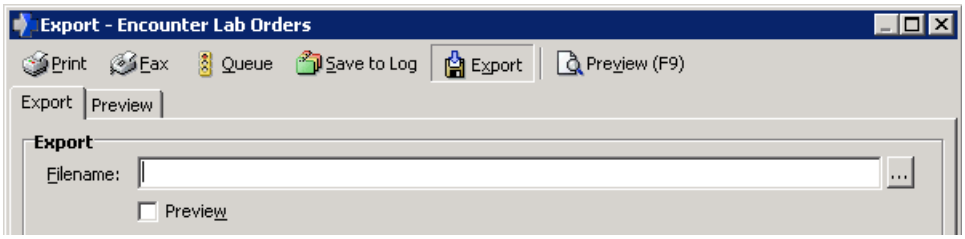


3. Enter a *Comment* if desired.
   Examples: “Please send additional copy of this document to Dr. X.” or “Patient will pick up after 3 PM.”
4. Click either **Queue** or **Save to Log** at the bottom of the screen.

NOTE: If you print an historical document from the Face Sheet, Explorer or Output Queue, the document is printed, based on the template as it existed in Output Manager at the time the document was originally generated. If you make changes to the template in Output Manager, you must regenerate the document in order for the changes to be reflected.

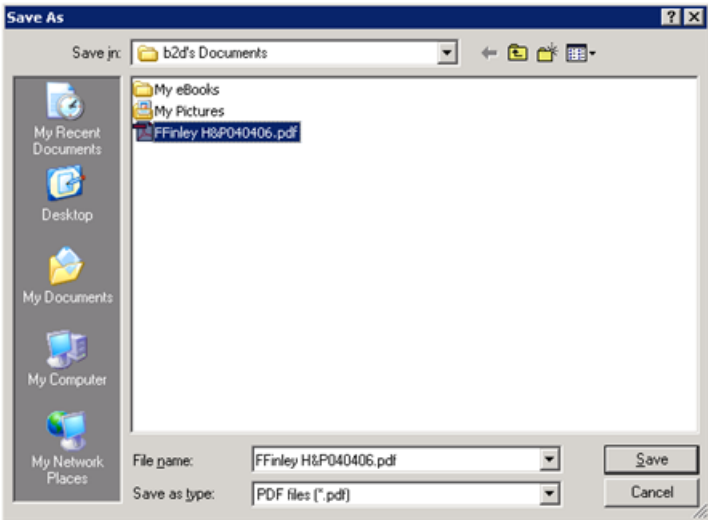
Exporting from any view

1. On the toolbar, click (Print Information) and select the template you need for the document you want to generate.
2. Click the **Export** tab



3. Click ... to open the Save As dialog box.

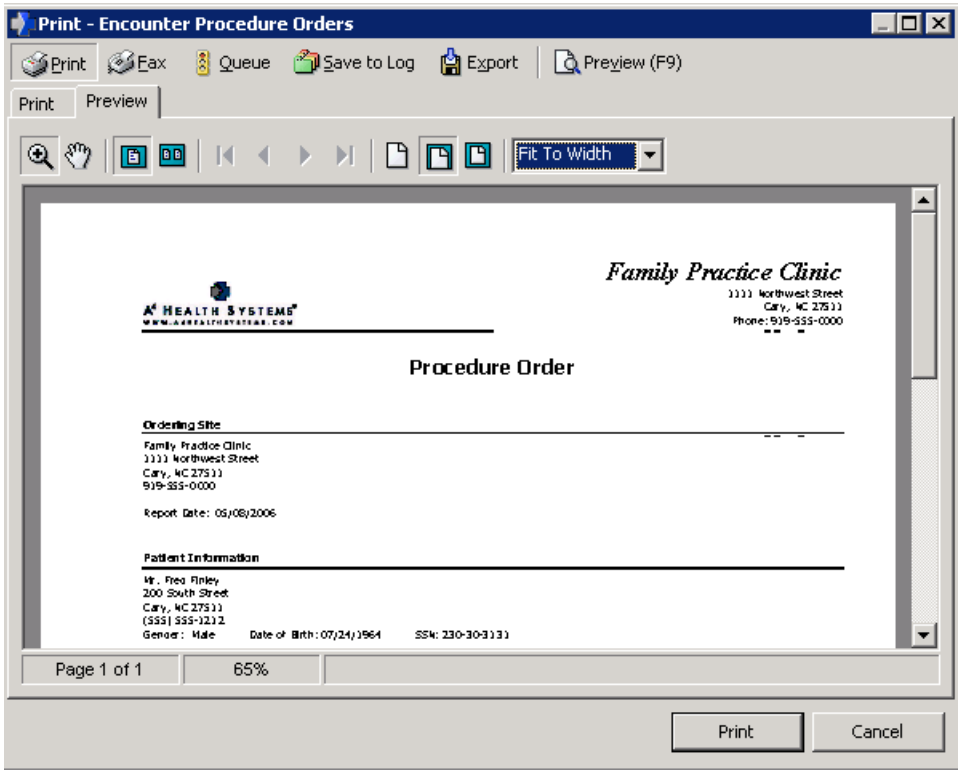
4. Click the **Save in** down arrow and navigate to the appropriate directory to locate the document.



5. Select the document and click **Save** to export the file and open the application associated with the file type.

Previewing documents from any view

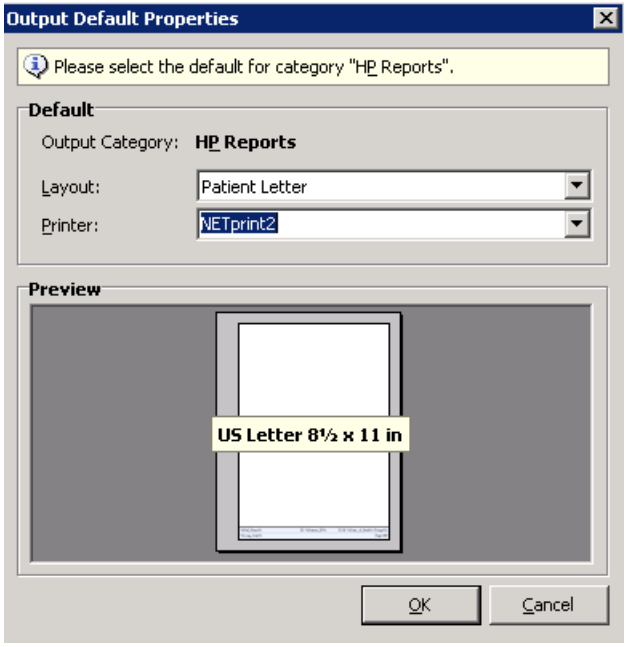
1. On the toolbar, click (Print Information) and select the template you need for the document you want to generate.
2. Click the **Preview** tab to view the selected document.



Output Defaults

Set site, location, and caregiver defaults for printers and layouts for each output category

1. On the application menu bar, select **Launch > Administration Module**, then access Output Defaults by doing **one** of the following:
   - **To set personal defaults** - On the Administration Module toolbar, click **My Output Defaults**.
   - **To set site defaults** - In the left pane, select **Site Settings >** **> Output Defaults**.
   - **To set location defaults** - In the left pane, select **Locations >** (select a location) **>** **> Output Defaults**.
   - **To set caregiver defaults** - In the left pane, select **Caregivers >** (select a caregiver) **>** **> Output Defaults**.
2. In the *Output Defaults* dialog box, select an *Output Category* and click (Edit Layout Default) or press **F2**.



3. Click the **Layout** and **Printer** down-arrows and select the appropriate items, then click **OK**.

Creating output default sets

A caregiver can have more than one Output Default set to accommodate default setting for different hallways or wings of a facility.

1. Access caregiver Output Defaults, either in the Administration Module (see Output Defaults on page 384) or from the Clinical Module menu bar (**Options > Edit Output Defaults**).

2. Select Output Defaults for each Output Category and click **Save Set**.
3. Enter a name for the *Printer Set* (**Example:** Hall A) and click **OK**.

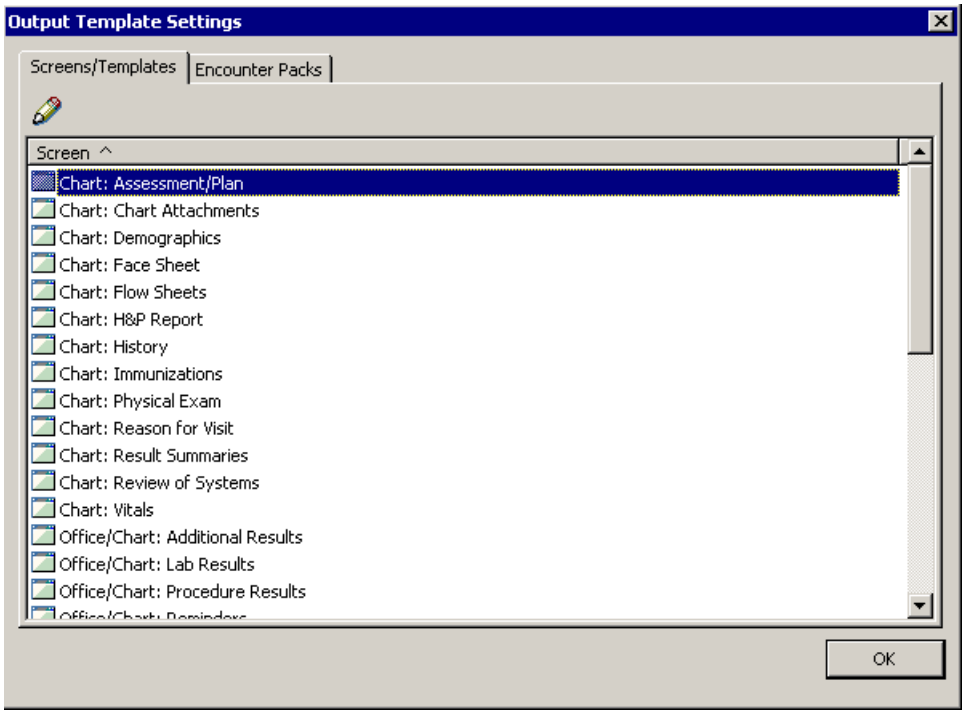
Using output default sets

1. From the Clinical Module menu bar, select **Options > Edit Output Defaults**.
2. Click the Set down-arrow to select the set you want to use.
3. Click **Apply Set** and **OK** (at the bottom of the screen) to exit.

Output Settings

To facilitate printing during a patient visit and at checkout, you can select output templates that you want to have available from each screen, and create encounter packs that bundle certain items in a print pack for various types of visits. You can select settings either by site, location, or caregiver in the **Administration Module**.

- **By site** - Select **Site Settings > > Output Settings**
- **By location** - Select **Locations >** (select a location) **> > Output Settings**.
- **By caregiver** - Select **Caregivers >** (select a caregiver) **> > Output Settings**



On the *Screen/Templates* tab, you can select the output templates that you want to be able to print from each screen (see Selecting output settings for each screen on page 386).

On the *Encounter Packs* tab, you can create bundles of document templates that can be printed, faxed, or queued all at once at signoff (see Encounter packs on page 388).

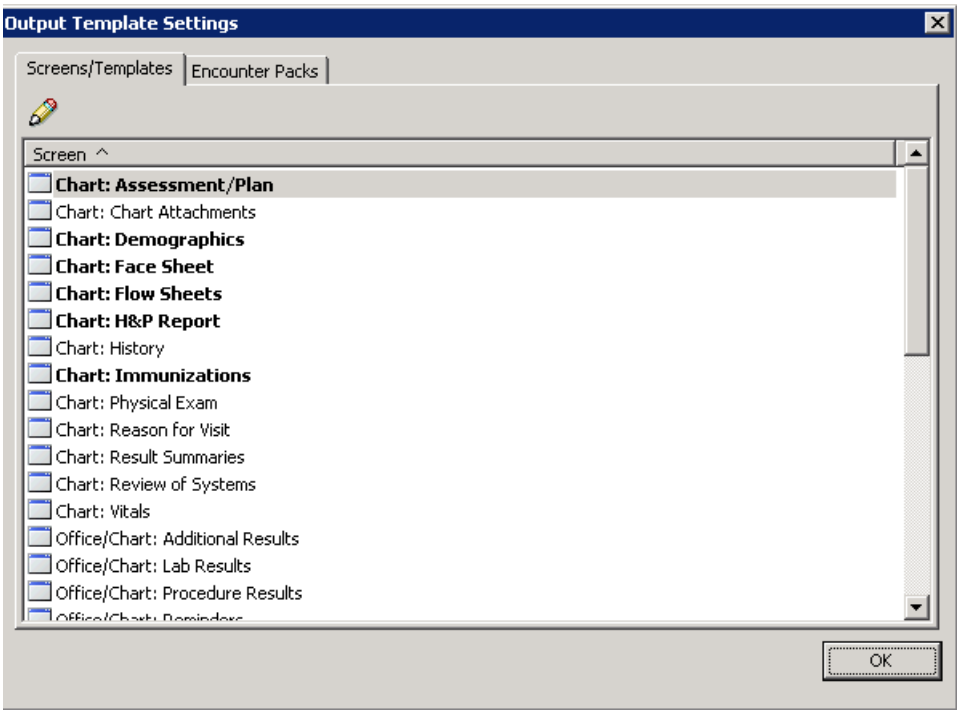
NOTE: When you assign templates to a view, the screen name is bolded.

Selecting output settings for each screen

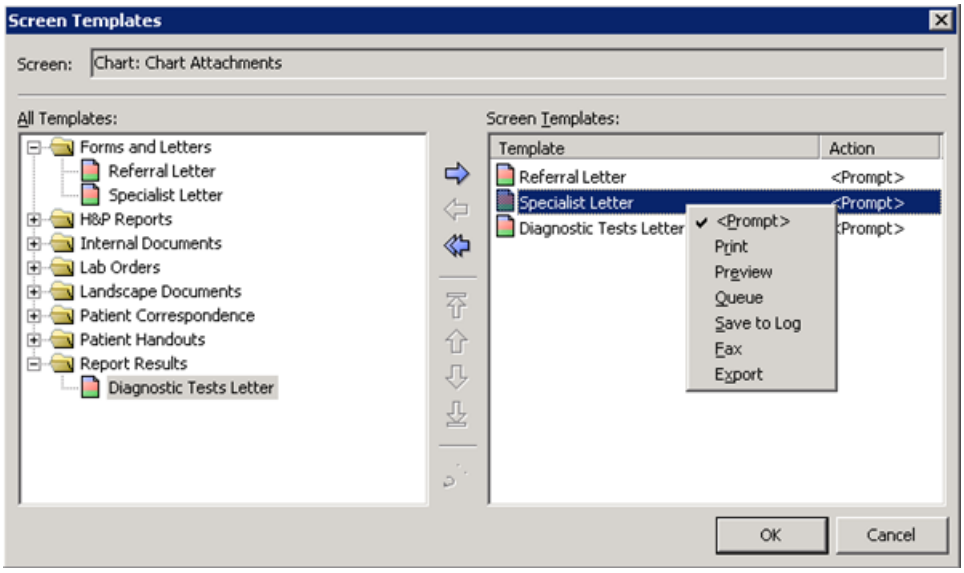
Access Screen Templates (to select templates available for a screen) from any of the following, depending upon the level at which you want to set them:

- **Site** - **Administration Module > Site Settings >** **> Output Settings**
  (These templates display under Site Templates in the drop-down list.)
- **Location** - **Administration Module > Locations >** (select a location) > **> Output Settings**
  (These templates display under *Location Templates* in the drop-down list.)
- **Caregiver** - **Clinical Module >** (from the toolbar on any view) **> Customize**.
  (These templates display under *My Templates* in the drop-down list.)

  NOTE: You can also customize caregiver output settings from the **Administration Module**.



1. In **Output Settings**, double-click the screen you want to customize.



2. **Select the templates** - At *All Templates*, open folders and double-click templates that you want to make available from the selected *Screen*.

3. **Determine the order** - Use the up-down arrows to put the templates in the desired order.

4. **Set actions** - In the *Screen Templates* box, you can set the action to be taken for each template by selecting it by clicking (Edit Action), right-clicking for a drop-down menu, or pressing **F2** and selecting the appropriate action. Otherwise, accept the default, <*Prompt*>, which allows you to select the desired action each time.

   NOTES
   * You can add a template more than once and assign different actions.

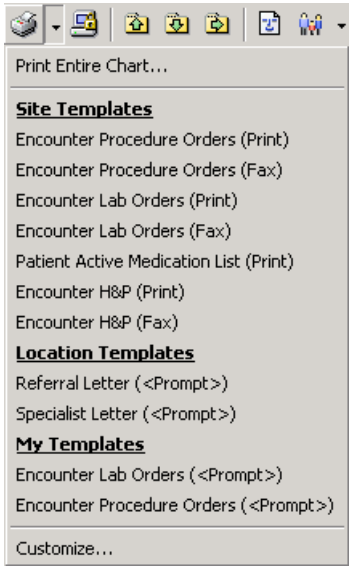
   * *Queue* and *Save to Log* both send the document generated to the *Output Queue*.

   * *Save to Log* is useful for the following items: consent forms containing patient signatures, documents requiring patient signatures on a hardware device at check-in or check out, documents that patients do not want a copy of, but that you may want to print later.

5. After selecting all templates and setting actions, click **OK**.

   NOTE: In Output Template Settings, screens with user-selected templates display in bold.

6. To see the templates you selected for each view, in the **Clinical Module**, access the view and click (Print) on the toolbar.

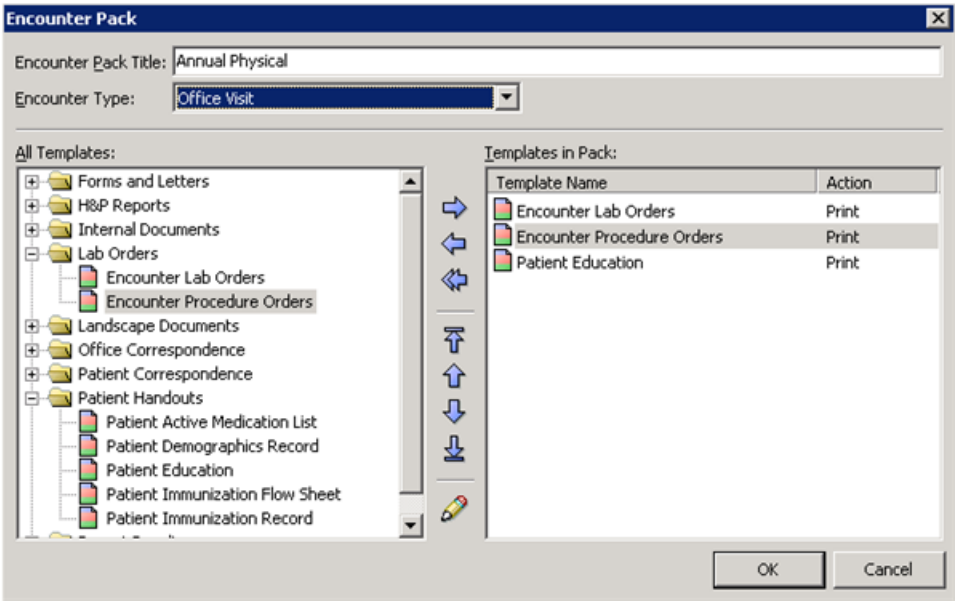


Encounter packs

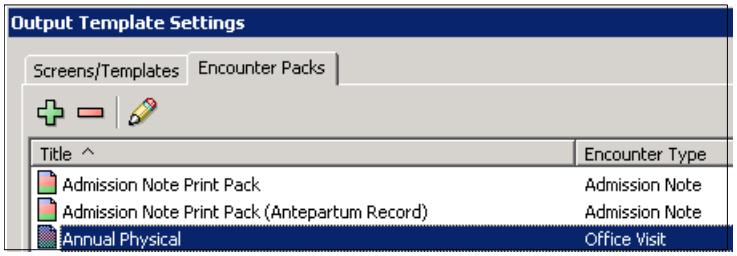
To facilitate printing at checkout, create bundles of output templates, called *Encounter* (or *Template*) *Packs,* for various encounter types and set the action for each template.

Creating encounter packs

1. Access Output Template Settings (see Output Settings on page 385).
2. Click the **Encounter Packs** tab and press **Insert** on your keyboard ***or*** click (Add Encounter Set) to display Encounter Pack.



3. At *Encounter Pack Title*, enter a descriptive name for your template pack.
4. Click the **Encounter Type** down-arrow and select the type of encounter for which you'll use this template pack.
5. At *All Templates*, open folders and double-click the templates that you want to bundle for the encounter pack.
6. Use the arrows to manipulate the order that the templates should appear.
7. In the *Templates in Pack* box, if desired, you can select template actions by clicking (Edit Action) or pressing **F2** and selecting the appropriate action. Otherwise, accept <*Print*>.
8. When you have selected all the templates for the encounter pack and their default actions, click **OK**. The new encounter pack is listed on the *Encounter Packs* tab by *Title* and *Encounter Type*.

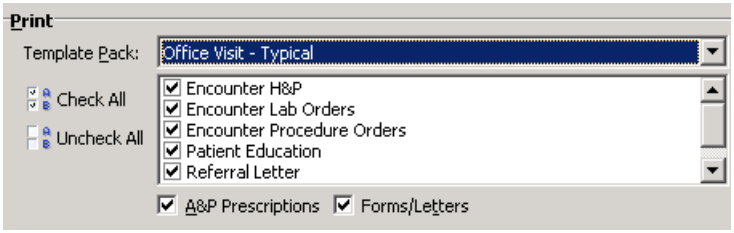


HINT: If you do not print documents at sign-off, create an empty encounter pack

9. Click **OK** to close Output Template Settings.

Using encounter packs

1. When you are ready to output your documents for an encounter, with the chart pulled, access the Print Template Packs by doing any of the following:
   - From (H&P Report) - Click **Sign Off *or*** click **Bill *or*** on the toolbar, click **> Draft**.
   - From A/P (Assessment/Plan) - On the toolbar, click **> Draft**.
2. At the bottom of Sign Off Chart, click the **Template Pack** down-arrow and select a pack to generate the documents you need for the encounter with one click.



3. Click **A&P Prescriptions** and **Forms/Letter** to generate these documents. They cannot be included in an encounter pack.

System-defined encounter packs

- Standard Print Pack (all encounter types)

    - Encounter Procedure Orders (Print)
    - Encounter Lab Orders (Print)
    - Specialist Letter (Print)
    - Referral Letter (Print)
    - Patient Education (Print)
- Standard Fax Pack (all encounter types)
    - Encounter Procedure Orders (Fax)
    - Encounter Lab Orders (Fax)
    - Specialist Letter (Fax)
    - Referral Letter (Fax)
- Office Visit Print Pack
    - Encounter Procedure Orders (Print)
    - Encounter Lab Orders (Print)
    - Specialist Letter (Print)
    - Referral Letter (Print)
    - Patient Education (Print)
- Office Visit Fax Pack
    - Encounter Procedure Orders (Fax)
    - Encounter Lab Orders (Fax)
    - Specialist Letter (Fax)
    - Referral Letter (Fax)
    - Patient Education (Fax)
- Nurse Visit Print Pack
    - Encounter Procedure Orders (Print)
    - Encounter Lab Orders (Print)
    - Patient Education (Print)
    - Encounter H&P (Print)
- Nurse Visit Fax Pack
    - Encounter Procedure Orders (Fax)
    - Encounter Lab Orders (Fax)
    - Patient Education (Fax)
    - Encounter H&P (Fax)
- Phone Encounter Print Pack
    - Encounter H&P (Print)

- Phone Encounter Fax Pack
  - > Encounter H&P (Fax)
- Consult Print Pack
  - > Encounter H&P (Print)
  - > Specialist Letter (Print)
- Consult Fax Pack
  - > Encounter H&P (Fax)
  - > Specialist Letter (Fax)
- Admission Note Print Pack
  - > Encounter Procedure Orders (Print)
  - > Encounter Lab Orders (Print)
  - > Encounter H&P (Print)
- Admission Note Fax Pack
  - > Encounter Procedure Orders (Fax)
  - > Encounter Lab Orders (Fax)
  - > Encounter H&P (Fax)
- Admission Note Print Pack (Antepartum Record)
  - > Antepartum Record Detailed [by Date] (Print)
- Admission Note Fax Pack (Antepartum Record)
  - > Antepartum Record Detailed [by Date] (Print)

Assigning access for refaxing or reprinting prescriptions

In the **Administration Module**, assign access for refaxing or reprinting prescriptions either by individual caregiver or by caregiver type:

- **Caregiver** - Select **Caregivers >** highlight the caregiver **>** **> Access > Clinical Module > Office Functions > Output Queue**, select **Refax/Reprint Prescriptions**.
- **Caregiver type** - Select **Function Access > Clinical Module > Office Functions > Output Queue**, select **Refax/Reprint Prescriptions**.

Quick Printing Reference

Printing from open encounters

1. Open chart and click printer icon on toolbar.
2. Select document from list of templates or from one of the template categories (**Example:** Forms & Letters, H&P reports)
3. Provide additional information if prompted to do so.
4. Select printer defaults if dialog opens.

Printing entire chart

1. Open patient's face sheet and click printer icon on toolbar.
2. Select **Print Entire Chart**.
3. Select items to include from chart and click **Print**.

Printing from appointments

Print the same way you would from an open encounter, **but** if you want patient specific documents, highlight the patient's appointment first.

Printing documents without signing off chart

1. From **A/P,** click printer icon on toolbar.
2. Select **Draft**.
3. Select **Template Pack** and click **Print**.

Printing forms/letters and prescriptions from A/P

1. From A/P, order referral, medication, etc.
2. Click **Print** or printer icon. (For prescriptions, it's on the *Prescription* tab.)

Printing no documents at sign off

Create an Encounter packs that contains no templates (see Creating encounter packs on page 388).

Regenerating documents from output queue

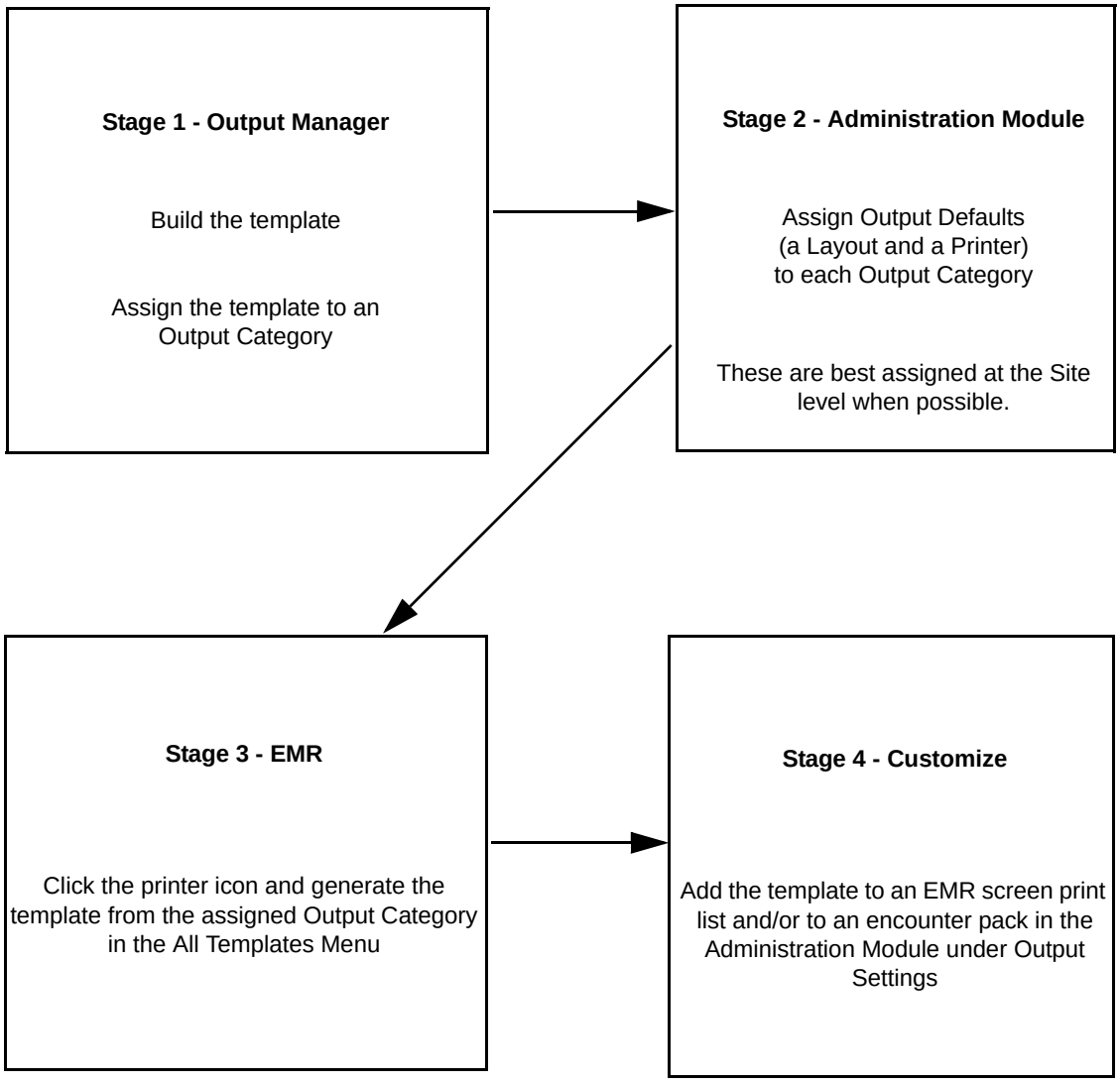
1. Set filters, select patient, and set *Status* to **<All Statuses>**.
2. **Right**-click document and select action: **Print, Fax, Save to Log, Export**.

   NOTE: For prescriptions, enter a reason for regenerating.

Generating queued documents

1. From desktop, select **Output Queue**.
2. Set filters and set *Status* to **<All Requiring Action>** to list all *Queued* documents.
3. Note *Destination/Comment* (if any) entered when document was queued.
4. **Right**-click document and select action: **Print, Fax, Save to Log, Export**

Document Stages


Stage 1 - Output Manager
Build the template
Assign the template to an Output Category
Stage 2 - Administration Module
Assign Output Defaults (a Layout and a Printer) to each Output Category
These are best assigned at the Site level when possible.
Stage 3 - EMR
Click the printer icon and generate the template from the assigned Output Category in the All Templates Menu
Stage 4 - Customize
Add the template to an EMR screen print list and/or to an encounter pack in the Administration Module under Output Settings

Index

A

access for refaxing/reprinting prescriptions 391
action history, output queue 96
action items
  definition of 77
  inbox messages 25, 28
  responding to 79
  status bar, review from 5
  toolbar icon 110, 113
  using 78
addenda
  H&P reports, adding notes to 156
  procedure results, adding notes to 311
additional results
  in patient manager 174
  overview 195
addresses, entering in demographics 164
administration
  electronic prescribing 66
  encounter packs, creating 388
  output
    defaults 384
    templates, selecting for views 386
  security for refaxing/reprinting 391
AFP, specimen collection screen 221
anatomical images, purchased database 238
annotating lab results 183
antepartum date selection 324
appointments
  billing information, displaying 21
  colors 7, 16
  locations, viewing by 16
  Ntierprise, accessing 17, 138
  patient manager 174
  pregnancy record, editing 335
  schedules, printing daiy 20
  scheduling in EMR 17
  searching for 19
  status bar, review from 5
  status, entering time 16
  time entered, correcting 16
  toolbar icon 110
  worklogs, tracking patients 104
ask-on-entry questions, answering 222
assessment/plan
  authored text, setting default for 320
  defaults, setting 122
  diagnoses, adding 294
  free text, adding 296
  history, viewing 291
  medications
    ordering 303
    patient education for 307
    using previously recorded 293
    viewing history 292
  methods of recording data 292
  my short lists, specifying 239
  overview 291
  problem history, viewing 291
  problem search, accessing 299
  procedure entry rules, using 309
  quick, using 321
  requisitions, creating from 300
  short lists, using 294
  toolbar icon 110
attachments
  encounters, moving to other 156
  face sheets, viewing from 210
  H&P report, viewing from 356
  office visits, linking to 209
  procedures results 192
audit open encounters
  description of 107
  toolbar icon 110
authentification, biometric 68
authored text 295
  defaults, setting 320
  processing 197
auto-logoff, setting/disabling 3
automatic inactivation of medications 158

B

back, toolbar icon 110
barcode labels, printing 228
batch processing
  accessing 228, 229
  deleting 231
  editing 231
  lab order batches
    creating 229
    editing 231
  manifests, printing 231
  toolbar icon 110
batch refill
  overview 89
  refill requests, processing 89
  toolbar icon 111
billing
  appointments, displaying charges for 21
  batches 17
  encounters 363
  information, viewing 354

procedures, defining billable status 188
pulling charts for 139
reconciliation 105
toolbar icon 111
biometric authentication
eRefill requests 55, 362
login 1
overview 68
preparing to use 68
printing/faxing 69
system options, setting 68
blood lead, specimen collection screen 222
blood type, entering 164
bookmarking favorite Internet sites 84
browser, Internet toolbar icon 111
build, where to find 4

C

calendars, using to enter dates 10
canceling contact 375
caregiver options
assessment and plan 122
defaults, overview 108
desktop 109
editing 108
electronic prescriptions 123
face sheet 114
history 126
my short lists 128, 240
order on behalf of another caregiver 302
patient manager 116
quick lists 127
reason for visit 118
results 117
review of systems/physical exam 119
sign off 124
title bar 125
toolbar 110
vitals 121
caregivers
display options 108
outbox, viewing other's 88
output default sets, creating 384
performance reviews, conducting 360
scheduled patients, viewing 17
worklog filter 100, 101
cervix, editing pregnancy record 331
charges, displaying in the EMR 21
chart attachments
adding 208
face sheets, viewing from 210
H&P report, viewing from 356
office visits, linking to 209
overview 208
toolbar icon 111
chart reviews
detailed 359
overall 358
charts
contact
canceling 375
tracking in worklogs 100
electronic, contents 139
file, toolbar icon 111
filing 143
internal transcription, viewing 155
merge 232
history 236
manually merging 232
queue, using 235
opening 141
outstanding messages 22
printing entire 144
privacy levels, setting 163
procedure results, attaching to 192
pulling 139
for billing encounters 139
for concurrent encounters 140
for non-billable contact 140
from status bar 5
toolbar icon 112
reason kept open 142, 355
received
displaying list of 80
viewed from status bar 5
viewing 143
reminders
creating 211
overview 211
viewing/completing 212
scanned documents, viewing 155
send, toolbar icon 113
sending to caregivers 142
signing off 364
viewing data 22
chief complaints
documenting 258
documenting details 262
clinical information 221
clinical products, where to find 4
Clinical Reference System
database 238
definition 295
collapse all, in A/P 294
collection information, entering 218
colors on

appointments 7
desktop stacks 7
columns, resizing 8
concurrent encounters, pulling charts for 140
consent of care agreement, entering 164
contacts, entering emergency information 171
counseling, E&M calculator 368
CPT
database 238
definition of 295

D

daily schedules, printing 20
data elements, definition of 377
data source libraries, list of 295
data, manipulating 8
data/risk, E&M calculator 370
databases, description of purchased libraries 238
date of birth, field format 141
dates
entering 10
historical procedures, editing 194
pen-based 13
deceased date, entering 164
defaults for
authored text 320
caregivers 108
locations 131
printers 130
quick filters 98
demographics
accessing 162
addresses/phone numbers, entering 164
data entry disallowed 171
emergency information, entering 164
entering/editing 163
guarantors, entering 164
insurance, entering/editing 167
Ntierprise, accessing from the EMR 138
pictures, loading 172
printing 166
privacy level, setting 163
referral caregivers, entering 163
toolbar icon 111
desk references, menu option 3
desktop
audit open encounters 107
defaults, setting 109
launching other HealthMatics modules 3
login 1
orientation 2
overview 1
preferences, setting 108
toolbar icon 111
diagnoses
assessment/plan, setting defaults 122
classifying and adding descriptions 299, 300
database libraries, searching 294
E&M calculator 367
face sheets
editing on 299
revising from 150
free text, using for 296
orders, associating with 308
primary/secondary/tertiary, assigning 297
short lists, selecting from 294
discharge plans data source 295
display options, setting 108
documentation pane, in ROS/PE 272
documents
approving/rejecting 71
exporting from any view 382
faxing from any view 381
inbox messages 25, 28
output queue, viewing from 92
overview 70
previewing from any view 383
printer defaults, setting 130
printing from any view 379
queued, generating 393
queuing/saving to log from any view 382
regenerating from output queue 392
saving to log 95
scanned 76
scanned, reviewing/approving 74
status bar, accessing from 5
toolbar icon 111
transcription, reviewing/approving 70
drafting encounters 361
drop-down lists, using 8
drugs, Medi-Span database 238
duplicate charts, merging 232

E

E&M calculator
accessing 367
data/risk 370
E&M level 367, 369
exam, default, setting 124
field definitions 369
level of service, adjusting 373
management options 370
overview of 366
service type, default setting 124
edit desk references, menu option 3
electronic charts, contents of 139

electronic prescriptions
  administration 66
  assigning agents for 66
  defaults, setting 123
  matching manually 57
  overview 55
  patients, matching 58
  pharmacies, matching 59
  sending new 63
electronic signatures
  output queue, adding from 94
  setting default for 124
emailing
  from face sheet 86
  from HealthMatics EMR 85
  from lab reports
    for all patients 186
    for one patient 186
emails, creating in EMR 85
emergency information
  contacts 171
  entering 164
employment information, entering 165
encounter packs
  creating 388
  overview 388
  system-defined, list of 389
  using 389
encounters
  attachments/messages, moving 156
  billing 363
  drafts, printing 361
  face sheets
    customizing view 115
    viewing/printing from 153
  finalizing 356
  history
    clearing current 250
    editing items 249
  open
    auditing 107
    toolbar icon 111
  procedure results, attaching 311
  review of systems 280
ePrescribe
  prescriptions, transmitting electronically 306
  synchronization, running immediately 67
eRefill requests
  administration, setting up 66
  approving 60
  biometric authentication 55
  inbox messages 25, 27
  matching manually 57
  matching unrecorded maintenance medications 60
  rejecting 62
  rejecting/sending new 63
  toolbar icon 111
erroneous entries
  correcting flowsheets 207
  immunization, marking 339
exam default, E&M calculator, setting 124
exam level, E&M calculator 367
exit, toolbar icon 111
exporting documents
  from any view 382
  from output queue 96
external transcription, approving/rejecting 71

F

face sheets
  accessing/viewing 145
  defaults, setting 114
  diagnoses
    editing 299
    revising 150
  emailing from 86
  encounters, viewing/printing 153
  flow sheets, viewing 146
  history
    viewing/revising 151
    viewing/revising problems 147
  medications
    inactivating 145
    interactions, viewing 146
    viewing/changing 157
  messages, viewing 42
  orders list 158
  problems
    inactivating 145
    revising 148
    viewing 147
  refill request documentation 90
  scanned documents, viewing 76
  toolbar icon 111
faxing
  backup for approvals 62
  from output queue 94
  overview 377
faxing, templates from any view 381
fetal/maternal data, editing 330
file chart, toolbar icon 111
filters, status bar icons 5
finalize procedure results 311
financial inquiry, accessing from the EMR 138
fingerprint authentification, biometric 68

flow sheets
erroneous entries, correcting 207
face sheets, viewing from 146
toolbar icon 111
fonts, uses for 8
former name, entering 165
forms/letters data source 295
formularies, using 308
forward, toolbar icon 111
free text
assessments/plans, adding 296
previously entered immunization history 343
reason for visit, using as 261
using for history documentation 254

G

general transcription, saving as attachment 72
granting access to messages 129
graphics, purchased image databases 238
graphs, for result summaries 203
growth charts
documenting 242
vitals 245
guarantors, entering in demographics 164
GYN cytology screen 220

H

H&P report
accessing 353
attachments, viewing 356
editing current 355
encounters, finalizing 356
face sheets, viewing/printing from 153
notes, adding 156, 356
reason kept open 355
signing off charts 364
toolbar icon 111
HCFA-1500 signature on file, entering 165
HCPCS
database 238
definition 295
head circumference, default settings 121
HealthMatics version, where to find 4
high priority
red 7
urgent message indicator number 78
history
current encounter
clearing items from 250
documenting past history items 251
editing items 249
defaults, setting 126
document using
free text 254
my short lists 240
previously entered history 248
search 254
short lists 252
face sheets
customizing view 115
viewing/revising 151
general, viewing and documenting 247
immunizations
documenting 338
editing 339
free text entries 342
previously entered free text, using 343
viewing 152
immunizations, adding 340
indicating none is on record 251
level, E&M calculator 367
medications, managing 255
merge 232
non-contributory 252
overview 247
printing problem lists 150
problems
managing 255
viewing/revising from face sheets 147
problems, from A/P 291
procedures, changing dates of 194
toolbar icon 111
hot keys 10

I

ICD-9
database 238
definition 295
icons, inbox 26
images
expanding mapped 119
messages/notes, adding into 33
physical exam notes, adding into 286
physical exam, documenting 289
immunization record
accessing/viewing 338
printing 338, 341
immunizations
adding historical 340
erroneous entries, marking 339
free text, using in history 342
history
documenting 338
editing 339
using previously entered free text 343
history, viewing 152

ordering 342
toolbar icon 111
import tab in messages and notes 37
importing files into notes 351
inactivating
medications automatically 158
problems/medications
from A/P 292
from face sheets 145
inbox
contents of 24
item icons, definition of 26
messages, removing 27
other caregivers', viewing 28
status bar filters 5
views, refreshing 26
insurance
adding to EMR database 169
editing in EMR database 170
entering/editing 167
interactions
face sheets, viewing from 146
medication warnings 306
internal transcription 135
viewing in charts 155
internal transcription, approving/rejecting 73
Internet
bookmarking favorites 84
toolbar icon 111

K

keypad
numeric 14
on screen 14

L

lab order entry
accessing 214
creating requisitions 215
overview 214
viewing lab orders 215
lab orders
batches
creating 229
editing 231
lab reports, emailing/printing
for all patients 186
for one patient 186
lab requisitions, creating from A/P 300
lab results
annotating during review 183
date selections 187
entering 175
face sheets, viewing from 159
finding 182
notification messages, rules 187
overview 175
patient manager, reviewing in 174
publishing with read receipts 184
reviewing 178
unsolicited, including in pregnancy record 336
view toolbar icon 113
viewing from review results 178
labels, printing barcode 228
launch, accessing other HealthMatics modules 3
lengths, documenting 288
levels, E&M calculator 367
libraries, list of data sources available 295
license information, where to find 4
LifeART database 238
lists
customizing quick lists 127
my short lists, setting options for 128
living will, entering 164
locations
appointments, viewing 16
editing defaults 131
login, name and password 1
logoff
automatic setting controls 3
toolbar icon 111
logs, saving documents to 95

M

machine worklog filter 100, 102
mail merges, performing 83
mail messages
sending and creating 37
toolbar icon 113
management options, E&M calculator 370
managing
medications, from history 256
problems/medications from history 255
manifests, printing 230
manipulating windows, panes, data 8
mapped images in physical exam 289
master lists, reason for visit 260
maternal/fetal data, editing 330
MDM level, E&M calculator 367
measurements
documenting 288
two-dimensional 276
medical history, editing 332
medication explorer, accessing 157
medications
assessment/plan, setting defaults 122

edit/reactivate 158
eRefills, matching unrecorded medications 60
face sheet
customizing view 115
viewing/changing from 157
history, viewing from A/P 291, 292
inactivating 145
automatically 158
from A/P 292
interactions, viewing 306
managing from history 255, 256
Medi-Span database 238
new, ordering 303
overview, ordering/viewing 303
patient education, printing 307
patient manager 174
previously recorded, using in A/P 293
refills, viewing/approving 46
Medi-Span
database 238
definition 295
menu bar, using 3
merge charts
history of 236
overview 232
merge queue, using 235
messages
chart, outstanding 22
entering data on tabs 32
forwarding to other caregivers 42
granting access to others 129
inbox messages 25
inbox, removing from 27
mail
creating and sending 37
toolbar icon 113
moving to other encounters 156
overview 32
patient
face sheet, viewing saved messages 42
toolbar icon 113
use of 39
patient manager 174
procedure results, about 193
replying to 40
status bar, review from 5
toolbar icon 111
urgent indicator, turning on/off 6
viewing 32
Microsoft Outlook, using to email from EMR 85
modules, launching from the desktop 3
my ROS (PE) lists tab
copying 270
deleting 270
editing 270
my short lists
adding to 294
assessment/plan, specifying 239
defaults, setting 240
deleting 129
history 240
overview of 239
reason for visit, specifying for 239
sorting and deleting 128
using 242

N

names, entering preferred/former 165
navigation in ROS/PE 266
map 267
my ROS (PE) lists 268, 269
ROS (PE) 266
search 271
selected 268
next appt, editing 335
nickname, entering 165
non-contributory history, entering 252
notes
assessment/plan, setting defaults 122
entering data on tabs 32
H&P report, viewing from 356
images
adding in physical exam 286
loading into 346
using 345
importing files into 351
overview 344
physical exam, adding 286
review of systems
adding to 282
characteristics level, adding 283
review of systems level, adding 282
systems level, adding 283
text 344
voice
entering 349
transcribing 135
notification messages
rules for routing 187
viewing 29
Ntierprise, accessing from the EMR 138
nursing services data source 295

O

OB history, editing 333
office manager, description of 7

office procedures data source 295
one-dimension measurements, documenting 276
open encounters
  report 107
  toolbar icon 111
options
  editing 108
  overview 108
ordering, on behalf of another caregiver 302
orders
  assessment/plan, setting defaults 123
  batches, creating 229
  face sheet
    customizing view 115
    viewing from 158
    viewing results from 159
  medications 303
  procedure rules, using 309
  toolbar icon 111
organ donor, entering 164
outbox
  accessing 88
  other caregivers', viewing 88
  toolbar icon 111
Outlook
  emails within the EMR, creating 85
  inbox, toolbar icon 112
  using to email from EMR 85
output
  defaults, setting in administration 384
  encounter packs, creating 388
output all, prescription properties dialog 51
output blocks, definition of 377
output default sets
  creating 384
  using 385
output queue
  action history, viewing 96
  documents, regenerating 392
  documents, viewing 92
  electronic signatures, adding 94
  exporting from 96
  new, creating 97
  overview 92
  queued documents, generating 393
  reprinting/refaxing 94
  toolbar icon 112
output settings
  selecting 385
  templates, selecting for each screen 386
outstanding chart messages 22

P

packing lists, printing 231
panes, resizing 8
passwords
  changing 108
  login to HealthMatics EMR 1
  setting refill request prompts 66
patient charts
  filing 143
  procedure results, attaching 192
  pulling 139
    for billing encounters 139
    for non-billable contact 140
  reason kept open 142
  received, displaying list of 80
  reminders
    creating 211
    overview 211
  sending to another caregiver 142
  transcription, viewing 154
  viewing 22
patient contact functions, description of 237
patient demographics
  accessing 162
  printing 166
patient education
  library of 295
  purchased database 238
patient manager 173
  accessing pregnancy record 323
  appointments, future 174
  defaults, setting 116
  messages 174
  toolbar icon 112
patient merges, merge queue 235
patient messages
  face sheets, viewing from 42
  forwarding to other caregivers 42
  patient manager 174
  responding to 40
  send toolbar icon 113
  use of 39
patient search 14
patient words, documenting 262
patients
  charts, merging 232
  demographics
    accessing 162
    entering/editing 163
  emailing/printing lab reports
    for all 186
    for one 186

insurance, entering/editing 167
matching for eRefills 58
medication
education, printing 307
history, viewing from A/P 292
merge history, reviewing 236
merges, manual 232
Ntierprise, accessing from the EMR 138
pictures, loading 172
problems/medications, managing 255
reminders, viewing/completing 212
searching for 140
visits, tracking progress 104
worklog 100, 103
pelvimetry, editing pregnancy record 334
pen-based functions, list of 13
pending messages, patient manager 174
performance dates, changing 193
performance reviews,conducting 360
pharmacies
calling in refills 89
entering NCPDP ID 60
matching 59
preferred, entering 165
setting up NCPDP IDs 67
phone numbers, entering 10
physical exam
accessing 284
defaults, setting 119
documenting 272
exam lists, using 284
measurements and sizes 276
using quick search 274
documenting from scratch 285
documenting measurements/sizes 288
images, using to document 289
navigation
map 267
my PE lists 268, 269
PE 266
search 271
selected 268
navigation methods 266
navigation pane 266
notes, adding 286
notes, adding images 286
preview pane 271
toolbar icons 112, 277
vitals, viewing 246
pictures
loading patient 172
purchased database of anatomical images 238
practice management system
entering demographic information in 162
Ntierprise access 138
preferences, setting 108
preferred name, entering 165
pregnancy record
accessing 322
cervix, editing in pregnancy record 331
documentation enhancements 322
documenting 325
maternal/fetal data, editing 330
medical Hx, editing 332
next appt, editing 335
OB history, editing 333
patient manager 174
pelvimetry, editing 334
printing 336
review of systems, editing 329
unsolicited lab results, including 336
prescribing agents, assigning 66
prescription properties, using 51
prescriptions
biometric authentication, printing/faxing 69
electronic
overview 55
sending new 63
setting up 66
history, viewing in A/P 292
security for refaxing/reprinting 391
transmitting electronically 306
viewing/approving 46
preview pane in ROS/PE, using 271
previewing, documents from any view 383
previous encounters, documenting in ROS 280
printers, selecting defaults for documents 130
printing
A/P, forms/letters/prescriptions 392
at sign off 392
barcode labels 228
batch manifests (packing lists) 231
charts 144
daily schedules 20
documents without siging off chart 392
encounters 361
entire chart 392
from appointments 392
from open encounters 392
from output queue 94
glossary of terms 377
H&P reports 153
immunization records 341
output default sets
creating 384
using 385

output queue 92
output settings, selecting 385
overview 377
patient demographics 166
patient education for medication 307
pregnancy records 336
problem lists 150
quick reference 392
requisitions 226
templates
from any view 379
selecting 378
toolbar icons 112, 380
priority items, red 7
privacy level, setting 163
problem lists, diagnoses, revising 150
problem search 299
problems
face sheet, viewing from 147
face sheets
customizing view 114
inactivating from 145
reviewing/revising from 147
history, viewing from A/P 291
status, revising 148
procedure entry rules, using in A/P 309
procedure results
charts, attaching to 192
encounters, attaching to 311
entering 189
entry dialog box 310
face sheets, viewing from 159
locating 193
overview 188
patient manager, awaiting review in 174
performance dates, changing 193
reviewing 191
view toolbar icon 113
viewing final 193
procedure rules, entering results 310
procedures
defining billable/nonbillable 188
historical, changing order dates 194
ordering using procedure rules 309
protocols, using 308
publishing lab results with read receipts 184
pulled charts, status bar icon 5
pulling charts 139
toolbar icon 112
pulse ox, definition of 244
purchased libraries, description of 238

Q

qualifier, E&M calculator 367
queue
definition of toolbar icon 380
documents from any view 382
merge charts 232
queued
documents, generating 393
merges, approving/rejecting 235
quick assessment/plan
toolbar icon 112
using 321
quick filters
creating 98
overview 98
user defaults, setting 98
using 99
quick lists, customizing 127
quick search, documenting in ROS or PE 274

R

read receipts 185
publishing lab results 184
reason for visit
defaults, setting 118
details, documenting 262
documenting 258
free text, using 261
master lists 260
my short lists, specifying 239
patient words, documenting 262
toolbar icon 112
view, purpose of 258
reason kept open
for pulled charts 142
H&P report 355
received charts
inbox messages 25, 28
list, displaying 80
status bar, review from 5
taking action on 80
toolbar icon 112
viewing 143
received documents
reviewing/approving 70
status bar, review from 5
reconciliation, billing 105
red, meaning of 7
refaxing/reprinting prescriptions, security for 391
references, menu option 3
referral caregivers, entering in demographics 163
referrals

caregiver letters, using 315
documenting 311
letters, selecting 311
ordering and documenting responses 195
results
entering 195
reviewing 197
refill requests
accessing 44
approving/rejecting 48
awaiting approval in patient manager 174
batch refill, processing in 89
batch refills, calling in 89
batch, toolbar icon 111
eRefill, toolbar icon 111
face sheet documentation 90
inbox messages 25, 27
passwords, setting prompts 66
recording 44
save to chart 49
send toolbar icon 113
status bar, review from 5
toolbar icon 112
viewing/approving 46
refreshing inbox view 26
reminders
creating on patient charts 211
patient chart 211
patient manager 174
toolbar icon 112
viewing/completing 212
report messages, processing 82
report results
patient manager 174
toolbar icon 112
viewing 198
reports
inbox messages 25, 28
requests regarding report results 82
toolbar icon 112
reprinting/refaxing from output queue 94
requisitions
accessing 227
batches, sending in 228
creating 214, 215
creating from A/P 300
deleting 226
printing 226
processing 227
resending 228
toolbar icon 112
reset list, in A/P 294
resizing, panes/columns 8
result notifications
blocking 31
determining who is notified 30
inbox messages 25, 27
toolbar icon 112
viewing 29
result summaries
graphs 203
graphs, viewing 203
overview 199
spreadsheets, viewing 202
toolbar icon 112
viewing 199
results
additional, in patient manager 174
awaiting review in patient manager 174
defaults, setting 117
entering using procedure rules 310
face sheet, reviewing from 159
lab
entering 175
reviewing 178
procedure
attaching to charts 192
changing performance dates 193
entering 189
locating 193
reviewing 191
referrals
entering 195
reviewing 197
report, in patient manager 174
status bar, review from 5
summary graphs, creating 203
unsolicited, including in pregnancy record 336
review of systems
accessing 278
adding notes 282
defaults, setting 119
documenting 272
from scratch 281
measurements and sizes 276
quick search 274
using previous encounters 280
navigation
map 267
methods 266
my ROS lists 268, 269
ROS 266
search 271
selected 268
navigation pane 266
notes

characteristics level, adding 283
review of systems level, adding 282
systems level, adding 283
pregnancy record, editing 329
preview pane 271
templates, using 278
toolbar icon 112
toolbar, using icons 277
reviews, conducting performance 360

S

save to chart, refill requests 49
save to log 95
scanned documents
charts, viewing in 155
face sheets, viewing from 76
not reviewed in patient manager 174
reviewing/approving 74
schedules
entering appointments in EMR 17
printing daily 20
status bar, review from 5
scroll bars, using 9
search
diagnoses 299
history, documenting 254
patients 14, 140
security
prescriptions, refaxing/reprinting 391
privacy levels on patient charts 163
send, toolbar icon 112
separator, toolbar icon 110
service level, adjusting in E&M calculator 373
service, E&M calculator default setting 124
sessions 3
short lists
history, documenting 252
in assessment/plan 294
sign off
charts 364
defaults, setting 124
from H&P report 356
signatures, include signature bitmap default 124
sizes, documenting 288
SNOWMED
database 238
definition 295
Social Security number, entering 163
Social Security number, field format 140
source prompt screen 219
specimen collection
entering information 218
promt screens 219
specimens
collection information, entering 218
collection prompts
AFP 221
blood lead 222
spell check
configuring 12
using 11
spreadsheets, viewing esult summaries 202
status bar
icon definitions 5
inbox filters, description of 5
synchronization, running immediately 67
system information, where to find 4

T

telephone numbers, entering 10
template packs
creating 388
system-defined, list of 389
using 389
templates
definition of elements 377
encounter packs, creating 388
exporting from any view 382
faxing from any view 381
output, selecting for each screen 386
previewing from any view 383
printing, from any view 379
queuing/saving to log from any view 382
review of systems 278
selecting 378
text tab in messages and notes 33
time
appointments, correcting 16
for visit, E&M calculator 368
title bar 2
defaults, setting 125
toggle tree, toolbar icon 113
toolbar
customizing 110
icons, description of 4
using ROS and PE 277
transcription 154
documents 70
external, approving/rejecting 71
general 72
internal
approving/rejecting 73
transcribing 135
patient manager, not reviewed 174
SOAP 72

U

unsolicited lab results, pregnancy record 336
urgent message indicator
  high priority number 78
  turning on/off 6

V

version, where to find 4
VIP, entering designation 165
vitals
  defaults, setting 121
  documenting 242
  entering data 221
  growth charts 245
  physical exams, viewing in 246
  toolbar icon 113
voice notes
  transcribing 135
  viewing in charts 155
voice tab in messages and notes 36

W

waist, default settings 121
web messages 185
  inbox messages 25, 27
  send toolbar icon 113
web publishing lab results 184
workflow, monitoring 6
worklogs
  appointments, tracking patients 104
  caregiver contact 101
  chart contact 100
  filters for 100
  machine contact 102
  patient contact 103
  toolbar functions, using 103
  toolbar icon 113